THE FINAL REPORT OF THE

EMERGENCY MEDICAL SERVICES REVIEW

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CHAIR

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ACKNOWLEDGEMENTS

The Emergency Medical Services Review did not begin its operations until July 1991, and despite an extremely large mandate, was obliged to report before the end of the calendar year. This document is the product of thoughtful and diligent work by a large number of individuals.

First, I would like to thank the thirty people representing the public, unions, independent operators and the provincial government who volunteered their time to serve on the four working groups which were the research backbone of the review. The membership of the groups can be found in the appendix.

The members of the steering committee, Rene Berthiaume, Yvonne Bondy, Graham Brand, Mark Lowell, Marion Lyver and Jim Thomas were forced to deal with some extremely contentious issues, yet went out of their way to respect, if not always agree with, each other's opinions. In the end, their common commitment to first class emergency medical services made it possible to find many co-operative solutions, in the form of consensus recommendations.

I must also thank the members of the review's Secretariat. Diana Murphy contributed able administrative support throughout. Bob Patrick provided excellent logistical support which insured that all Working Group and Steering Committee Meetings ran smoothly. Dennis Brown was always available to steer the review through the elaborate bureaucracy of the ministry, as well as helping out in numerous other ways, from developing minutes of the group meetings, to coordinating outside research. I am particulary grateful for this assistance, given that all these tasks were done on top of his regular formidable job at the Emergency Health Services Branch. Last and most important, I must acknowledge the work of Moya Beall, who served as the full-time coordinator of the review. She was responsible for just about everything from arranging and attending all working group and steering committee meetings, coordinating communications with interested parties, and drafting the background and consensus recommendation sections of this report. It would have been impossible for me to survive the past six months as part-time Chair of the review without her help.

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EXECUTIVE SUMMARY

It is generally agreed that Ontario's emergency health care system delivers a high standard of care in an efficient manner. But the system is facing a number of challenges that if left unaddressed, could create inequities in both the type and quality of services received by people across the province.

The Emergency Medical Services Review was established by the Ontario Minister of Health to provide advice on system governance and structure of the emergency health system, labour/management relations, service issues and staffing, training and career development issues. A steering committee was struck to oversee the work of four working groups and to put forward recommendations on these issues.

The committee reviewed three models for the future structure of the ambulance service. The independent operators proposed that all ambulance and dispatch services be run by independent authorities (public or private) under a modified provincial licensing system. The unions called for the creation of a single Crown agency to provide all ambulance service. An incremental change option, developed at the Chair's request, involved maintenance of the status quo, except for converting licenses into service contracts with independent operators and centralizing collective bargaining.

No consensus on structure was possible, and the resulting recommendations were developed by the Chair. He believes that a provincial commission, reporting to and funded by the Ministry of Health, represents the best long term structure for the Ontario ambulance service. The commission would be implemented gradually to insulate the existing parties in the system from massive dislocation. When a service was transferred to the commission, employees and operators would generally be given equivalent employment with the commission. Private operators would have the choice of ceding their license to the commission in return for financial compensation or continuing operations indefinitely, under renewable service contracts. Hospitals would be given up to six years to relinquish their services to the commission, but, where feasible, the commission would attempt to keep the service located on the hospital premises. Existing municipal services, which were unwilling to share the costs of ambulance provision along the lines of the Metro Toronto arrangement, would be given up to six years to relinquish the service. Volunteer services would coexist with the commission, indefinitely.

The labour relations environment is largely a consequence of the proposed structure. There would a single provincial bargaining unit for all ambulance officers and dispatchers, where the commission paid 100% of compensation costs. In the beginning, this would mean an employer coalition of commission and independent employers negotiating with a single union (or union council) to produce a master collective agreement.

Given the essentiality of emergency ambulance services, an unlimited right to strike would not be appropriate. Nonetheless, all parties prefer a limited strike to interest arbitration. In a limited strike, sufficient employees would be available to answer emergency calls, but all non-emergency transport would cease.

Although there is no desire to intrude on the bargaining environment of the Metro Toronto Ambulance Service, the issue of essentiality cannot be ignored. The parties must develop a plan to insure that all emergency ambulance calls are covered, in the event of a strike by other members of the bargaining units involved.

A wide-ranging series of consensus recommendations has been proposed by the steering committee on service and staffing issues.

The committee recommends the adoption of a minimum response time standard and implementation of appropriate changes to achieve and improve on this standard. On the issue of tiered response, it emphasizes that a community based, consultative process is necessary to determine whether and how to implement tiered response agreements. As detailed consultation on this issue was not possible, given the time constraints and limited resources of the review, the committee recommends the development of appropriate processes to guide the implementation of tiered response. A series of recommendations were made to revise the ministry's criteria for implementation of Advanced Life Support services. To improve provision of non-emergency transfers and to provide better utilization of ambulance resources, the committee recommends tiering ambulance services within the system, based on severity of patient condition. In addition, hospitals should receive a patient transportation budget, out of which all patient transport, including ambulance should be paid.

On staffing issues, steering committee recommendations include restructuring the ambulance system to allow a greater variety of career options, examination of the possibility of developing an early retirement program, and public relations programs designed to improve public recognition and appreciation of the emergency health care system. Job-related stress should be viewed as a compensable illness by the Ontario Workers' Compensation Board and the ministry should develop critical incident stress and stress management programs for ambulance personnel. Community colleges should expand the ambulance officer training program to permit accreditation at the Canadian Medical Association Level II, and, at the appropriate time, the Ministry of Health should make graduation from an accredited Level II program a prerequisite for challenging the Emergency Medical Care Assistant (EMCA) certification examination.

A detailed listing of all recommendations follows immediately.

RECOMMENDATIONS

A. STRUCTURE AND GOVERNANCE

A1. - A4. and A17 are consensus recommendations of the steering committee.

A1. Regardless of the future structure of the system, substandard operations should not be part of the service. There is need for development of criteria and methods of evaluation that utilize an educational approach, wherein necessary changes are discussed with the operator/manager. Operators, who disagree with the findings of an evaluation, should have the right to appeal through the existing Health Facilities Appeals Board.

A2. Where it is appropriate to tier the ambulance system into emergency and non-emergency services, this should be accomplished to ensure that the non-emergency service continues as an important component of the emergency health care system, which would be operated within the system.

A3. Most individuals currently working within the emergency health care system, regardless of where they work and what they do, are dedicated and committed to a system that consistently delivers a high standard of care. Regardless of the future structure, all competent and qualified individuals should be encouraged to work within the new system.

A4. The new system must be responsive and accountable to local community needs and simultaneously, maintain uniformly high standards. To enhance this capability, there should be an advisory committee structure that is broadly representative of those working within the system, as well as consumers, that will have the broad mandate of ensuring that the system delivers high quality emergency health care in a way that respects community needs.

A5. The Ambulance Act should be amended to create the Emergency Health Services Commission which would eventually become the sole provider of all air and land ambulance services, including dispatch, in the province. The EHS Commission would be established as a type 3 Crown Agency, making it totally distinct from the Ontario Public Service. It would report to the Minister of Health and continue to be funded by the province.

A6. The EHS Commission would be composed of three senior officials from the Ministry of Health (ie. The Assistant Deputy Ministers of Community Health, Institutional Health and Consumer Health and Planning), one from the medical profession and one from the community at large.

A7. The new EHS Commission would be the employer of all those working in the five air ambulance services, the Central Ambulance Communications Centres, the nine ministry-run services, and the Emergency Health Services Branch of the Ministry of Health. The Director of the Emergency Health Services Branch would report directly to the commission.

A8. The existing regional branch structure would be expanded upon in the new EHS Commission

to allow for greater community involvement (through District Health Councils) into ambulance service issues.

A9. If a service is transferred from an independent operator to the EHS Commission, it is understood that the all competent and qualified employees and managers of the independent service would receive equivalent positions as employees or supervisory personnel with the commission. In addition, the commission must provide fair compensation for any assets purchased or leased from the operator, at the time of transfer. The operator should be allowed to appeal the commission's financial offer for assets to the Health Facilities Appeal Board.

A10. The Ambulance Act should be amended to revoke existing ambulance licenses. The EHS Commission would then issue three year service contracts to former licence holders. Renewal of the contract would be subject to acceptable service provision in the preceding period. Renewals would not be unreasonably denied, and would be reviewable by the Health Facilities Appeal Board, or an equivalent arbitration process.

A11. If a private licensed operator would rather not continue to provide ambulance service under a contract basis, the operator should receive compensation equal to three times the current annual Management Compensation Plan (MCP). If, after a single three year contract, an operator, who is eligible for renewal based on acceptable service, agrees not to renew, he/she should be paid compensation equal to 1.5 times the current annual MCP. If, after any subsequent contract, an operator, who is eligible for renewal, but decides to cede the service to the commission, he/she should be paid compensation equal to .5 the current annual MCP.

A12. When the four existing service contracts to provide ambulance service expire, the commission should take over operations in that area.

A13. The EHS Commission should take over hospital based ambulance services on a staggered basis. Individual hospitals should be given the option of relinquishing the service immediately, or following up to two three-year service contracts. Where feasible, the commission should attempt to reach an agreement with the hospital to keep the ambulance service located on the hospital premises.

A14. Municipalities should be allowed to opt out of the EHS Commission's operation of ambulance services, provided that the commission would reimburse municipalities for only 75% of approved expenditures. The municipality would be expected to pay the remaining costs of providing its own ambulance services.

A15. Existing municipal ambulance services which are not willing to pay their share of operational costs, should be required to relinquish the service under the same terms as hospital services.

A16. Licensed volunteer services should be allowed to continue providing ambulance service, through three year renewable contracts.

A17. The EHS Commission should develop a unified point system for remuneration of volunteers, similar to that utilized by volunteer fire departments.

A18. The EHS Commission should provide training programs for volunteers to increase skill levels.

B. LABOUR/MANAGEMENT RELATIONS

All consensus recommendations except B5.

B1. *There should be a single province-wide bargaining unit for all ambulance officers (air and land) and dispatchers who are funded entirely by the EHS Commission. On the employee side, a single bargaining agent would be certified, following the certification rules outlined in the Ontario Labour Relations Act. The bargaining agent could potentially be a council of the existing unions, or an individual union. The employers would be represented by a coalition of the EHS Commission and the independent operators. Central bargaining would cover at least the major financial issues - wages and benefits. The parties would no doubt agree that some issues were better left for local bargaining, rather than being part of the master agreement.*

B2. *The administrative staff of the EHS Commission would not be part of the bargaining unit described above, but would be entitled to representation under the rules of the Ontario Labour Relations Act.*

B3. *The Metropolitan Toronto Ambulance Service should be exempt from the provincial bargaining unit, allowing the parties to bargain directly. In the future, municipalities who provide service under a similar cost-sharing plan, would have their employees moved from the commission to the municipal jurisdiction, similar to Ontario's provincial/municipal policing model.*

B4. *Prior to collective bargaining, the parties would be required to determine the proportion of the ambulance officers and dispatchers required to work in the event of a strike to guarantee that all emergency calls would be serviced. Any disagreement as to the appropriate numbers to be designated essential, and unable to strike, would be submitted for resolution to the Ontario Labour Relations Board. Following the designation process, if the union felt that a strike was not feasible because the overwhelming majority of positions were designated as essential, then the union would have the right to opt for interest arbitration.*

B5. *If the only feasible alternatives for dispute resolution are an unlimited strike or interest arbitration, interest arbitration should be used, as is the case with firefighters and police.*

B6. *Regardless of the specific bargaining unit(s) that ambulance officers and dispatchers belong to in Metropolitan Toronto or other future cost-sharing municipal services, the parties must agree on procedures for maintaining sufficient staff to respond to emergency ambulance calls, in the event of a strike by other bargaining unit members.*

B7. The scope of bargaining for the ambulance industry should be identical to the private sector.

B8. Arbitration of rights disputes should be governed by the rules covering the private sector embodied in the Ontario Labour Relations Act.

C. SERVICE ISSUES

All consensus recommendations.

C1. It is recommended that the entire province be covered by the 911 system, to ensure public access to rapid dispatch, and that this be mandated by legislation.

C2. The 911 system should be accessible to people who are hearing impaired.

C3. Consideration should be given to the concept of individual customer billing by the telephone carrier to finance the 911 project.

C4. Dispatching protocols should be designed and consistently monitored to deliver a multi-agency response as quickly as possible.

C5. The entire province should be covered by the Central Ambulance Communications Centre (CACC) system and this should be accomplished by 1998.

C6. All ambulance dispatchers should be trained to provide telephone instructions for cardio-pulmonary resuscitation (CPR), first aid and pre-arrival assistance, utilizing an approved priority medical dispatching system.

C7. The ministries of Health, Solicitor General and Transportation should jointly explore the possibility of strategically placed telephones on highways in rural and remote areas.

C8. The placement of hospital indicator signs should be reviewed by the Ministry of Health and Ministry of Transportation to ensure that the public is being directed to facilities with 24-hour emergency capacity, where there is a physician on site or on call 24 hours per day.

C9. The EHS branch should be encouraged to develop a pilot project, to explore alternative medical dispatch systems under controlled circumstances. The pilot project should include coaching of callers to provide initial first aid/CPR. There should be an evaluation and recommendations made by those involved in the pilot, as well as experts in standard medical priority dispatch, to determine whether the program should be implemented throughout the province, including Metro Toronto. Implementation should begin as soon as possible.

C10. An Ontario Heart and Stroke Foundation approved 'Heart Saver' course, or equivalent, and a standard first aid course should be a mandatory prerequisite to obtain a driver's license.

C11. CPR training should be included in the Ontario high school curriculum.

C12. CPR and first aid training programs should be targeted towards groups who are likely to be exposed to situations requiring use of these skills, for example, families of heart patients, teachers, public transit workers and other employees working in areas where there are regularly large crowds.

C13. The province should adopt the following response time standard for all dispatched Code 4 calls:

- Response time is defined as the amount of time from receipt of call by dispatch until the ambulance crew arrives at the scene.

- The response time standard shall include the maximum CACC reaction time of one minute and the maximum crew reaction time of two minutes.

- The minimum acceptable target response time, from receipt of call, until arrival at scene, shall be eight minutes for large urban areas, 13 minutes for urban/suburban areas and 23 minutes for rural areas. Of all Code 4 calls, 90 per cent shall be serviced in less than 10 minutes in large urban centres, 20 minutes in urban/suburban centres and 30 minutes in rural areas. In remote or wilderness areas, where response times are contingent on the circumstances of the call, ongoing evaluation must be made of the service's capacity to respond to all contingencies.

C14. Where standard minimum response times are not being met, the Ministry of Health should review its methods of station location, the need for satellite stations, as well as vehicle and staff deployment. Changes should be implemented to achieve minimum response time standards.

C15. The time of arrival at the patient's side should be recorded by ambulance officers and be reported to CACC's. The information should be used in efforts to reduce response times.

C16. The Ministry of Health should approach the Ministry of Municipal Affairs and Housing to ensure that all municipalities make provision for ambulance bases in zoning and site developments.

C17. Tiered response should be defined as a collaborative community emergency response between public safety agencies to assist with patient care. Patient care includes site preparation and assistance, safety, as well as medical care. The goal is to get a trained person to the patient as fast as possible. Collaboration is built on the recognition that the ambulance service has primary responsibility for prehospital patient care, fire services have primary responsibility for rescue and police have primary responsibility for scene and crowd control. Tiered responders may be ambulance, fire, police, first response teams, coast guard, Ministry of Natural Resources personnel, or other personnel as determined by a municipality or region.

C18. The development of tiered response agreements should be facilitated by regional ambulance offices, in collaboration with base hospitals. They would consult with municipalities

and ensure that all relevant agencies were involved in the development of a tiered response agreement appropriate to the community's needs.

C19. When tiered response agreements are initiated, the question of liability must be dealt with.

C20. Those designated to be the first responders in a tiered response agreement - that is, the agency that arrives within the three - five minute response time required for cardiac arrest situations - should be trained in CPR, first aid and oxygen therapy.

C21. Upon arrival of the ambulance to the patient's side, the first responder should transfer responsibility for patient care to the ambulance officers.

C22. Tiered response agreements in any community should define appropriate roles for each agency in cases such as cardiac arrest, airway obstruction, respiratory arrest, haemorrhage, chest pain, violent and uncooperative patients, extrication, scene safety, disaster management, hazardous materials and access problems.

C23. The existing Public Services Liaison Committee should be expanded to include ambulance operator, consumer, medical and municipal representation. It should address matters such as the need for standardized dispatch protocols for tiered response, with an emphasis on ensuring appropriate utilization of resources for Code 4 calls; development of generic tiered response agreements and an orientation course; development of guidelines for implementation of fire fighter defibrillation programs, or other response agencies, where appropriate. It is the expectation of the steering committee that fire fighter defibrillation would be an exceptional occurrence, as the ambulance service has primary responsibility for patient care. Where fire fighter or other agency defibrillation programs are implemented, they must be implemented jointly with the ambulance service.

C24. All agencies should be encouraged to implement the federal government designated common radio channel for on-scene inter-agency communications.

C25. Tiered response agreements should be reviewed, evaluated and revised as necessary at regular intervals to ensure that the system is working effectively and meeting its stated goals.

C26. In communities that choose to implement fire fighter or other agency defibrillation, the Ministry of Health, through the base hospitals must provide standards, medical control and certification.

C27. The Ministry of Health should take a lead role in the development and coordination of patient care policy and guidelines, universal precautions for infectious disease, tiered response orientation programs, joint training ventures for common skills and equipment, common data collection, and joint public relations and education ventures.

C28. The first criteria for implementation of ALS programs must be that the ministry will establish base hospitals or associate base hospitals across the province by 1994, as per the

current EHS Strategic Plan. This is a necessary prerequisite, to ensure ongoing medical control of the Advanced Life Support pre-hospital program. The base hospital program must be appropriately resourced and audited.

C29. *There is a need for a shared understanding and resolution within the EHS sector of the role of base hospitals. Base hospitals should be involved in the development, coordination and implementation of emergency health systems in their communities. The EHS branch should work with the Base Hospital Advisory Group, and representatives of ambulance operators and unions to prepare a document that defines the general role of base hospitals and permits specific roles to be worked out in individual contracts.*

C30. *The ministry currently requires that an ALS program proposal be endorsed by the district health council (DHC) and district and area EHS committees. The steering committee is concerned that at times DHC's and EHS committees may make decisions on ambulance services without direct involvement of individuals and organizations engaged in these services. To ensure broad-based representation in the ALS planning process:*

a) Each Base Hospital Utilization Review Committee should have representation from ambulance service providers, with both management and elected worker representation;

b) The Base Hospital Utilization Review Committee should have formal, or at least, informal representation on district and area EHS committees;

c) District health councils should ensure that all appropriate parties, such as police services, fire fighters, ambulance operators, ambulance unions, base hospitals, etc. have been fully consulted when making decisions on emergency health service issues.

C31. *The ministry currently requires that there be research evidence showing positive outcome on mortality before implementing an ALS procedure. The committee recommends that this criteria be retained for the expansion of certain ALS procedures, specifically the administration of intravenous (IV) drugs and IV fluids, and intubation; provided that the Research Advisory Committee use part of its budget to actively assist in the development of this research which would focus on both mortality and morbidity. The Research Advisory Committee should work collaboratively with base hospitals to develop standard research designs and implementation procedures.*

C32. *The ministry currently requires that a community have 911 service in order to receive automated defibrillation services. This requirement should be maintained, although the steering committee has recommended that the entire province be covered by 911 services, elsewhere in this report.*

C33. *For pain relief, or symptom relief, research and 911 should not be prerequisites, but base hospitals are necessary for medical control, and implementation depends on available funding. A symptom relief program should include a needs analysis and assessment of patient conditions that the program will affect; documentation of ambulance call volume and patient type; an*

evaluation of initial training needs and identification of continuing medical education and clinical practicums for ongoing skills maintenance; description of evaluation mechanisms to ensure quality control; and a description of how the program will be implemented operationally. Although not a prerequisite, a design for publishable research should be encouraged. The outcome, or therapeutic endpoints must be defined, and should include both negative and positive impacts and expected patient care benefits to be derived.

***C34.** The College of Physicians and Surgeons should explore removing 'pain relief' from the list of delegated medical acts.*

***C35.** Data must be collected by all programs for needs analysis and once a program is implemented, for purposes of on-going evaluation. The province and where appropriate, municipalities must provide assistance and resources as required.*

***C36.** Community colleges should consider future implementation of ALS training modules. These modules should be developed in cooperation with base hospitals and include an assessment and reporting module. Such modules should be standardized throughout the province.*

***C37.** Consideration should be given to having a member of the Provincial Base Hospital Advisory Group sit on the Research Advisory Committee, assuming she or he is qualified to act in this capacity.*

***C38.** The existing system wherein the sole responsibility for certifying ambulance officers to perform delegated medical acts rests with the base hospital medical director, should be maintained. As is now the case, officers would perform only those acts for which they have been certified, regardless of training level attained at a community college or other training institute.*

***C39.** The patient transport system should be tiered into three categories, according to severity of the patient condition: 1) air ambulance, critical care transport unit and paramedic vehicles for the most severely ill or injured, 2) ambulance vehicles for Codes 1 - 4, with possible designation of the vehicles for Codes 1 and 2, where appropriate, as ambulance transfer vehicles, such as multi-patient units, where appropriate; 3) and the range of services that exist outside of the ambulance system, such as taxis, personal vehicles, Wheel Trans, etc.*

***C40.** Hospitals should be given more responsibility for patient transportation decisions, in the form of a transportation budget, out of which all patient transport, including ambulance, would be paid.*

***C41.** Institutions should attempt to determine what is the most appropriate mode of transport, based on the criteria that patients who require a stretcher and/or on-going medical attention should be transferred via land or air ambulance. An ambulance crew should be in attendance for Codes 1 and 2 transfers.*

***C42.** The ministry should develop criteria for use of non-ambulance vehicles.*

C43. Receiving hospitals should institute block booking for those services used by patients requiring ambulance transport. This would define times giving priority to these patients.

C44. Non-urgent transports should be booked by sending facilities at least 24 hours in advance through a CACC.

C45. There should be a scheduled transportation system in the north that delivers people to centres offering block booking.

C46. Codes 1 and 2 calls should be done on a door-to-door basis. Institutions should be given ambulance stretchers to facilitate this procedure.

C47. The EHS and Institutional Care branches of the Ministry of Health, the Ministry of Community and Social Services and the Ontario Hospital Association should establish an implementation group to work with DHC's to develop a multi-tier system of patient transport and care, that functions on a door-to-door basis, that schedules the departure and arrival of patients, utilizes the concept of block booking, attempts to develop appropriate response time standards and enhances career development within the ambulance system. Any cost savings realized through the development of efficient patient transfers would be reallocated to other aspects of health provision in those geographic areas.

C48. Where volumes warrant, dedicated transport vehicles operating either on a schedule or ad hoc basis should be implemented by ambulance services. These vehicles would be exempt from answering emergency calls and would be staffed by ambulance officers.

C49. The EHS should do extensive education with hospitals, nursing homes and home care services and their sponsoring ministry departments to encourage use of non-ambulance services for patients who can appropriately use them.

C50. Non-ambulance patient transport services should be regulated.

D. RECRUITMENT, RETENTION, MOBILITY AND CAREER DEVELOPMENT

All consensus recommendations.

D1. Greater value in both monetary and non-monetary terms should be placed on employees within the ambulance system.

D2. To promote retention and mobility and to acknowledge the need for modified work programs, the pre-hospital emergency care system should be restructured to allow for greater variety of job opportunities. New career options within the system could include training and public education programs, public relations and non-emergency transfers.

D3. The Ministry of Colleges and Universities should be encouraged to promote more cross

career training.

D4. *Applicants should be made aware at the recruitment stage of the nature of the work and the demands it places on those performing it.*

D5. *Promotion programs should be focused to attract individuals from the target groups into the service. Provided that all applicants to college training programs are qualified, they should be admitted on employment equity considerations, rather than on a first come, first served basis. Child care must be provided in the colleges, both to attract women to the program and to recognize and support parental responsibilities of men.*

D6. *The profession must be made more attractive and accessible to the target groups. There should be an examination of the services to determine appropriate programs, for example, child care, job accommodation, four for five programs (where employees work for four years at 80 per cent of remuneration, bank the remaining 20 per cent and take the fifth year off), and improved outreach in recruitment.*

D7. *There should be labour/management committees established where they do not already exist, to enable the parties to discuss and resolve day to day operational issues.*

D8. *There should be a mechanism to permit greater involvement of managements and unions in ministry policies.*

D9. *Training programs to improve management techniques and to encourage a more progressive and participatory management style must be established for both management and employees.*

D10. *Appropriate legislation and/or regulations should be amended and enforced, to remove the possibility that ambulance officers are required to perform inappropriate duties.*

D11. *Ambulance workers need a name and an identity that indicates their work and the service they provide.*

D12. *Addressing the internal morale problem is a prerequisite to addressing the low status and profile of the service. Attention must be paid to the physical presence of the service - both in terms of location and visibility in the community and in terms of physical comfort of those working in the service. All existing ambulance stations must meet the ministry's minimum standards according to a date and plan determined by the ministry's response to the proposed amendments to the Occupational Health and Safety legislation dealing with health facilities. The plan should be made public on or before December 31, 1993.*

D13. *There should be better promotion of the emergency health care system. Promotion programs must be focused on recruitment, to attract competent applicants and to apprise them of the nature of the work. Promotion efforts must also be directed to the popular media, to create a higher level of public recognition and appreciation of the service.*

D14. Ambulance officers should be encouraged to enhance their professional status. This could occur through formation or membership in a professional association or through trade union activity designed to increase professional status.

D15. The Ministry of Health, in conjunction with the service operators and trade unions, should investigate the potential for establishing an early retirement plan for ambulance officers. To emphasize the importance of this proposal, it must be noted that identical recommendations were made by the Emergency Medical Attendant Review, and the Shapiro Commission.

D16. Job related stress should be viewed as a compensable illness by the Ontario Workers' Compensation Board.

D17. Appropriate levels of staff are needed to provide service and maintain complement when staff are called outside of the ambulance service's coverage area. The EHS branch should re-evaluate staffing levels and develop appropriate standards for staffing and workload levels through a standard-setting process with broad input and ensure that the standards are maintained at all times, within available resources.

D18. There are no ongoing critical incident stress management programs provided at the local level for emergency health care workers. Programs are organized on an ad hoc basis with fire and police departments after the occurrence of a major incident. There should be an ongoing program developed by the government and made available to all emergency health service employees, with appropriate support and resources.

D19. There is little stress management training within the service. The Joint Occupational Health and Safety Committee should be charged to deal with stress, as a high priority. It should examine such initiatives as the development of ongoing programs providing stress training and stress coping strategies. It should also advise the ministry on the development of an organizational delivery mechanism for ongoing stress programs, such as the development of stress management counsellor positions, with special consideration given to ensuring that these programs are accessible locally to all who work within the system.

D20. Stress training and coping strategies should be included in the college training program.

D21. There is no present requirement for defensive driving training. Many graduates of the college-based Ambulance and Emergency Care program have never driven an ambulance, as some colleges offering the course do not have ambulances. Defensive driving training in an ambulance should become part of basic training for ambulance officers.

D22. The Ministry of Health should ensure appropriate communications equipment throughout the ambulance service. There is a need for portable communications devices for the crew to ensure full communications ability and to prevent an occupational health and safety incident related to poor communications.

D23. The EHS branch should educate hospitals and other health care facilities to encourage them to advise dispatch of the patient's weight.

D24. There should be a greater emphasis on physical fitness by management and employees. It is understood that recommendations on physical fitness standards will be forthcoming from the Joint Occupational Health and Safety Committee.

D25. Standardized physical fitness programming should be part of the college training for ambulance officers.

D26. There should be improved education of management and employees regarding their rights and obligations in unsafe or potentially unsafe situations. Officers, for example, should be encouraged to call for help in situations requiring unreasonably heavy lifts.

D27. Ambulance officers should have all information pertinent to the care and safety of the patient and themselves. Protocols should be established to ensure that dispatch is informed of any potentially hazardous situation of heavy lifting, infection, violent behaviour, etc. and that ambulance officers are informed at the time of dispatch, to ensure that they are prepared for the situation.

D28. The practice of part-timers of working back-to-back shifts for different employers could affect the care of the patient and is a potential health and safety problem for the worker. The practice should be discouraged.

D29. The Joint Occupational Health and Safety committee should examine the body of knowledge regarding the impact of shift work and produce an educational package for employees and management explaining how shifts should be scheduled and outline useful lifestyle and coping strategies.

D30. The Ambulance and Emergency Care Program taught in Ontario's community colleges would be accredited at the Canadian Medical Association Level II, if it included training in two procedures, initiation of IV therapy and administration of nitrous oxide. To permit accreditation at the CMA Level II, the Ambulance and Emergency Care Program should be expanded to include training in these two procedures. In addition, the Ministry of Health, at the appropriate time, should make graduation from an accredited Level II program a prerequisite to challenging the EMCA certification examination.

D31. The colleges should be encouraged to introduce greater practical examination during the training of ambulance officers. A formal preceptor program should be developed by the Ministry of Colleges and Universities as soon as possible. This should include appropriate training, certification and remuneration for preceptors.

D32. There should be a sufficient period of on-the-job orientation to introduce new employees to matters such as WHIMS, occupational health and safety, driving skills, system and local policies and procedures, and local geography.

D33. Limited availability of educational facilities in remote areas make it a necessity to consider alternative hiring standards in these locales. Nonetheless, the Ministry of Colleges and Universities should be responsible for developing innovative programs to extend educational opportunities to these remote areas.

CHAPTER 1

BACKGROUND INFORMATION UTILIZED BY THE REVIEW

INTRODUCTION

In February 1991, then Health Minister, Evelyn Gigantes, announced a review of emergency medical services. With a particular emphasis on delivery of pre-hospital care, the review was to focus on future directions, governance and labour/management relations.

Ontario's emergency medical care system has delivered a consistently high quality service to the people who use it. On measures such as cost per call, cost per capita, response time, etc., Ontario compares well with other jurisdictions.

But Ontario's system is facing a growing number of challenges. Changing demographics, changes in the way health services are being delivered, and the introduction of new technologies have placed new pressures on emergency health resources. To ensure that the goals of equity and access are maintained, the management and organizational structures of the system must be capable of responding to these new pressures.

Like other health services, the emergency medical care system is under increasing financial pressure. Declining federal transfer payments and increasing demand for all types of health services means that new funding is limited. This creates an even greater need to ensure that existing resources are used to best advantage and are co-ordinated effectively with other health care and emergency services.

Motivation for change comes also from those who work within the emergency health care system who want to address a number of issues relating to their work and working relations. The issue of career development has been a matter of long-standing concern, as well as the desire to ensure that everyone working within the system is well trained and able to work to their full potential.

Another issue is the recognition of the need to develop rational structures and processes for labour/management relations. This was reinforced by the determination of Ontario Public Service Labour Relations Tribunal that employees of certain ambulance services are Crown employees within the meaning of the Crown Employees Collective Bargaining Act and that the owner/operators were Crown agents.

The task for the review was complex and comprehensive: to provide advice to the Minister on future directions, governance, service and staffing issues and employer/employee relations. The review was to submit its final report to the Minister by December 31, 1991.

The Terms of Reference for the review were very specific:

1) to examine the future needs of the emergency land and air ambulance services in Ontario;

2) to strengthen non-emergency (inter-institutional) transportation services to meet community needs, recognizing changes in demographics and the effects of technology on the delivery of health care;

3) to explore opportunities for the improvement of service delivery and communication linkages with allied emergency service providers;

4) to improve standards to assess management and service delivery;

5) to examine the current management service delivery structures (ministry, hospital, municipal, private, volunteer) and recommend future governance arrangements;

6) to address the implications of the Tribunal's decision and the settlement for the entire ambulance sector, where a number of unions have representation;

7) to examine labour management relations and develop recommendations for the improvement of collective bargaining practices for ambulance services; and

8) to review existing legislation governing emergency service operations and collective bargaining arrangements.

The document constitutes my attempt to fulfil this mandate, in a time frame provided. The report is organized as follows. The remainder of this chapter presents this background information about the ambulance industry in Ontario, followed by a description of the processes used by the review to generate the information necessary to make recommendations. Since the future structure and governance was, by far, the most contentious issue, the chapter concludes with in-depth explanations of various structural models presented by the parties of interest and garnered from research commissioned by the review.

The following chapter consists of four sections with rationale and recommendations for structure and governance; labour relations; service issues and staff training and development, respectively.

A BRIEF HISTORY OF THE AMBULANCE SERVICE IN ONTARIO

Prior to the late-1960's, ambulance services in Ontario evolved in an ad hoc manner and were operated by private operators, hospitals, municipalities and volunteers. There was no provincial government funding for ambulance services - payment was on a fee-for-service basis by the patient - and there were no uniform standards for patient care, training or equipment.

In 1968 the Ontario government took responsibility for the development, control and funding of the 400 ambulance services in the province.

The then Ontario Hospital Service Commission (OHSC) was granted licensing powers under the Ambulance Act. It embarked on a program to upgrade ambulance services. This involved, in part, the rationalization of services within communities, often placing services under

administration of a hospital, and at times, the outright purchase of ambulance services by the commission. The upgrading program also involved the development of an ambulance personnel training program and the development of vehicle standards. It was at this time that the commission began centralized purchasing of all new ambulance vehicles and equipment, such as communications equipment and patient care devices.

In 1973 ambulance services became the responsibility of the newly created Ontario Ministry of Health. The mid-1970's saw a reversal of the trend begun in the 1960's, with a new emphasis on private sector involvement in the management and delivery of ambulance services. From 1968 to 1973, licensed ambulance services could not be sold between operators. An operator could only sell to the OHSC. Since 1973 service licenses and assets have been bought and sold as business undertakings.

Throughout the 1970's, and 1980's the ambulance system continued to evolve, with the development of a central ambulance communications system, a college training program and an air ambulance service.

THE PRESENT SYSTEM

The present structure of the system reflects its patchwork history. There are seven different types of ownership within the ambulance system. The ministry operates five dedicated air ambulances and also contracts with general aviation contractors on a per trip basis.

Nine of the 177 land ambulance services operating in the province are directly owned and operated by the Ministry of Health and four are run on contracts with the ministry. Sixty-six services are owned and operated by hospitals, 28 by volunteer services and four by municipalities. One of the municipal services is the Metro Toronto Ambulance Service, the largest in the province; the other municipal services serve small communities. Forty-four of the services are owned and operated by private companies and 22 services are run by a relatively new category of operator, agents of the Crown. The last group are private operators who were accorded this new status by regulation, following the determination of the Ontario Public Service Labour Relations Tribunal that McKechnie Ambulance Services Inc. in Collingwood, Ontario, was a Crown agent.

Last year the system handled a total of 1,180,022 calls. Of these, 519,846, or 44 per cent were emergency calls (Codes 3 & 4).

All medically-necessary ambulance services for residents of Ontario are included in the Ontario Health Insurance Plan, although patients who are not being transferred between health care facilities are charged a co-payment of $25.00. The average cost of the call, which would be charged to non-residents, is $185.00.

Independent operators submit an estimate of projected expenses for the following year. The

ministry determines the amounts to be paid to each operator and pays the amount in instalments throughout the year, with a year-end adjustment, based on final costs. Operators are responsible for paying expenditures over the approved budget. Private operators' budgets include a management compensation package based on call volume and the number of ambulance stations managed.

The Ministry of Health funds 100 per cent of all ambulance operations, determines all staffing levels, owns all the vehicles and owns or controls all dispatch services. The single exception is Metropolitan Toronto.

The ambulance service in Metro was amalgamated into a single municipally operated service in 1975 after a consultant's report commissioned jointly by the ministry and Metro Toronto recommended a single service. Prior to this time, ambulance services in Metro were provided by five privately operated services, as well as one municipally operated service and one ministry operated service, both in the City of Toronto. The goal was to improve efficiency and effectiveness of the service by amalgamating it under one management and dispatch structure.

At the time of the amalgamation, the Ministry of Health agreed to pay 75 per cent of approved costs. Over the years the Metro service has decided to make expenditures beyond the approved level and the ministry contribution has dropped to its current level of 53 per cent of costs.

While it meets ministry standards, the Metro Toronto service owns and operates its own dispatch, owns its vehicles and equipment, negotiates collective agreements without ministry guidelines, and conducts its own training of personnel. This unique arrangement led to the mutual decision of the Ministry of Health and the Metro service that its separate status would not come under the purview of this review.

There are a total of 3,893 ambulance officers working in the province, including 2,335 working full time, 1,049 working part time and 509 volunteers. There are also 466 dispatchers working in the 13 ministry-run Central Ambulance Communications Centres and in the 9 independently-run dispatch centres.

Three major unions represent ambulance officers and dispatchers. The Ontario Public Service Employees Union (OPSEU) represents ambulance officers and dispatchers working for the ministry, as well as some employed in private and hospital services. The Canadian Union of Public Employees (CUPE) represents ambulance officers and dispatchers employed by Metro Toronto, as well as some employed by private and hospital services. Service Employees International Union (SEIU) primarily represents ambulance officers and attendants employed by hospital services, as well as some employed by private operators.

Collective bargaining in the ministry-run services is conducted between the union and the government as part of the Ontario Public Service negotiations under the Crown Employees Collective Bargaining Act. Negotiations outside the ministry have historically been conducted between the licensed operator and the bargaining agent. Unionized ambulance officers employed

in private and municipal services have the right to strike; those working in ministry and hospital services do not.

THE "McKECHNIE AWARD"

The determination by the Ontario Public Service Labour Relations Tribunal that certain operators are Crown agents, or the "McKechnie Award", as it has commonly referred to, is the result of an application to the Tribunal by the Ontario Public Service Employees Union for a determination that McKechnie Ambulance Services Inc. is a Crown agent.

The reason for the application, was that while collective agreements in non-ministry services are negotiated between the licensed operators and the bargaining agent, the wage rates and benefits have always been subject to Ministry of Health approval and funding. In fact, operators have insisted on including this provision in collective agreements to protect themselves against being held liable for payment of amounts negotiated beyond the ministry's approved budget increase. Bargaining agents and operators alike have expressed frustration at what they regard as the "ghost at the table". This process, intended or not, allowed previous provincial governments to settle at one compensation rate for ministry-run services, while forcing independent operators to take a tougher bargaining line with their respective unions. Thus the government was shielded from the political fallout of ambulance service collective bargaining, yet reaped the benefits in terms of lower compensation costs.

The Tribunal assessed the relationship between McKechnie Ambulance and the Ministry of Health to determine the level of control by the latter. It used the fourfold test established through jurisprudence: 1) control 2) ownership 3) chance of profit 4) risk of loss and also the question of whose business it is.

In November, 1989, the Tribunal concluded that:

a) there was no significant aspect of the operation of the ambulance service that is within the control of McKechnie Ambulance;

b) none of the major items used to provide the ambulance service are owned by McKechnie;

c) McKechnie has no opportunity to maximize profit through exercise of independent discretion or business acumen;

d) there is little or no risk of loss; and

e) the business of providing an ambulance service in the Collingwood area is the business of the Ministry of Health and accordingly, that McKechnie is a Crown agent.

This was followed by a similar ruling on Owen Sound Ambulance Services. As a result of these decisions, the Ministry of Health designated 21 private ambulance services by Regulation as agents of the Crown for purposes of collective bargaining. A master collective agreement was subsequently negotiated centrally with the Crown agents, as well as a local agreement with each one.

STRUCTURE AND PROCESS OF THE REVIEW

A number of considerations led to the organizational structure of the review and the processes it adopted. The scope and complexity of the issues to be addressed in a relatively short time frame, combined with the unquestionable need to involve all appropriate parties, led to the development of a working group structure, whose work would be directed by a steering committee.

A steering committee was established to represent labour, operators, consumers, emergency medicine, the Ministry of Health and Management Board of Cabinet. Four working groups were established to examine questions relating to system governance and structure, labour/management relations, service issues and staffing, training and career development. The role of the working groups was to provide information to enable the steering committee to put forward recommendations to the Minister.

The working groups were comprised of representatives appropriate to the issues being considered. Consumer representatives on the steering committee and working groups were appointed on the basis of both their involvement in health planning matters, including an involvement in District Health Councils, and out of concern for appropriate regional and gender representation on the review.

Secretariat assistance was provided through the Ministry of Health, Emergency Health Services Branch.

I was appointed as chair of the review in July 1991. Final appointments were then made to the steering committee and the working groups. Given the realities of summer commitments, it was not possible to convene working groups until the beginning of September.

At the first steering committee meeting in July, I informed the parties that I saw my role as being similar to a fact finder. When there was consensus on the steering committee about an issue, it would become a recommendation in the report. If no consensus was possible, after stating the positions, I would recommend the superior alternative in my estimation. Virtually all recommendations on issues other than structure and governance are based upon a steering committee consensus.

The steering committee approved issue statements to be used to guide the working groups. We also decided to retain external consultants to develop a comparative study of organizational

structures used by ambulance services in other jurisdictions and to conduct a literature search of Advanced Life Support issues.

The committee also agreed that a bulletin would be issued periodically to a communications list of interested organizations and individuals, to keep them apprised of the review's activities and to encourage written submissions on matters under consideration.

Working group meetings began in early September and continued roughly every three weeks until the end of November/early December. Each group developed suggestions and recommendations for the steering committee.

Throughout their deliberations, working groups were mindful of the province's worsening economic situation. While the financial outlook did not determine the ultimate goals envisioned by the recommendations, the groups were conscious of the need to provide reasonable, cost-effective recommendations to the steering committee.

Working group deliberations relied greatly on the diverse perspectives brought to the table to achieve a comprehensive understanding of the issues. The general approach was to develop a consensus on potential solutions. Where this was not possible the differing points of view were noted.

These discussions were also informed by invited presentations from groups and individuals knowledgeable about the issues being discussed, and by a variety of studies, articles and other written materials on the issues.

The review was conscious of the regional diversity of the province and attempted to include, as much as possible the perspective of people from northern, remote and rural areas of Ontario. I attended the semi-annual North West Regional Ambulance meeting at the Quetico Centre, near Atikokan and met with representatives from the Northeastern Area Emergency Health Services Committee. The system governance and structure working group spoke with a representative of hospitals in Northern Ontario who operate ambulance services. A central concern expressed to the review was the need for the system to be responsive and accountable to local communities. It was also emphasized that policies designed for urban southern settings would not necessarily be appropriate for northern rural communities.

WORKING GROUP ACTIVITY

Service Issues

This working group was asked to provide advice on a variety of complex issues confronting Ontario's emergency health system. These included response time; tiered response, or coordination of the system with other emergency response systems; the expansion and implementation of Advanced Life Support services and methods of providing non-emergency

transfers.

The group was comprised of individuals representing consumers, ambulance operators, unions, base hospitals, the Ontario Hospital Association, the Ministry of Health, the Ministry of the Solicitor General and the Provincial Emergency Health Service Advisory Committee. The group requested that the consumer and medical representatives on the steering committee attend its meetings to create a strong liaison between the consumer representatives involved in the review.

In recognition of the complexity of its task and short time frame, early in its deliberations the group decided to rely on its own expertise as much as possible and to minimize presentations from outsiders.

Response time discussions were based on the knowledge of the group and written background information. The working group emphasized to the steering committee that response time was the most crucial issue of its deliberations.

On the issue of tiered response, the working group requested presentations from Dr. Justin Maloney, medical director of the Base Hospital Program at Ottawa General Hospital, and from Bernard Moyle, the Ontario Fire Marshall. Dr. Maloney was invited because of his experience in setting up a tiered response program in the Ottawa area, which involved consultation with a variety of parties, not all of whom were initially in favour of the concept. Mr. Moyle was invited to provide an overview of fire fighters' perspective toward tiered response.

Unfortunately the limited time frame and resources of the review did not permit detailed consultation with fire and police services. A brief was received from the Ministry of the Solicitor General and I met with representatives from the Ontario Association of Fire Chiefs, the Provincial Federation of Ontario Fire Fighters, the Ontario Professional Fire Fighters Association and the Fire Marshall.

It was emphasized to the review that a community-based, consultative approach was required to develop tiered response agreements, involving municipalities and the range of parties who could be involved. This was important because of the number of different agencies involved, all with different responsibilities, and because the agencies were responsible to different levels of government.

As background for its discussion on Advanced Life Support services (ALS), the group invited presentations from Dr. Chris Rubes, medical director of the Base Hospital program at Sunnybrook Medical Centre and from Dr. Marion Lyver, medical advisor to the Ontario Ministry of Health Emergency Health Services Branch. The review commissioned a literature survey on ALS from the Department of Prehospital and Emergency Medicine at McMaster University. The survey has not been completed. (The Emergency Health Services Branch will assume the contract, as it anticipates that the literature review will be useful for its purposes.) Fortunately, material supplied to the working group through the branch and from Dr. Maloney provided a useful overview of current literature on ALS.

To inform its discussion on non-emergency transfers, the group heard presentations from Norma Boyd, Chair, Inter-Facility Non-Emergency Task Force, Emergency Health Services Committee of the Regional District Health Council, and Louise Roseborough, project manager of the Ottawa-Carleton District Health Council, reporting on the findings of the task force; Hugh Kerwin, from Physically Handicapped Independent Advancement Community Services (Phiacs); and David Evans, project officer, Emergency Health Services Branch, describing the ministry pilot projects dealing with non-emergency transport. The group also received considerable documentation on the issue, including the Ontario Hospital Association Summary Paper on Non-Urgent Transfers and the 1985 Ministry of Health report on Inter-Hospital Patient Transportation.

Recruitment, Retention, Mobility and Career Development

This working group was asked to direct its attention to a number of long-standing issues affecting those who work within the emergency health system: recruitment, retention and career mobility within the sector; stress and burnout of ambulance and dispatch workers; early retirement and a variety of training issues.

The working group was comprised of representatives from operators, unions, base hospitals, the Ministry of Colleges and Universities, the Ministry of Health and Human Resources Secretariat.

Like the service issues working group, this group decided to minimize outside presentations and rely as much as possible on its own knowledge, experience and expertise.

The group developed a shared understanding of problems relating to retention, recruitment, mobility and career development, based on presentations from group members and general discussion.

The group used a similar process for its deliberations on stress, relying on the wealth of written material and videos provided by the Emergency Health Services Branch, the unions and by working group members.

To aid its training discussions, the group invited Dr. Chris Rubes, chair of the Canadian Medical Association Conjoint Committee for the Accreditation of Educational Programs in Emergency Medical Technology to explain the accreditation process and the CMA accreditation levels.

Labour/Management Relations

This working group was asked to advise on labour/management relations and collective bargaining structures and practices. Operators, unions, the Ministry of Labour, Ministry of Health and the Human Resources Secretariat were represented on the group.

It was agreed that certain matters were most appropriately left to the collective bargaining process; in particular, discussions of wage parity, benefits and pensions.

The group met with the management and labour representatives from Quebec and British Columbia to discuss labour/management relations issues in those jurisdictions.

Working group deliberations focused on aspects of the labour relations environment: degree of centralization in negotiations, scope of bargaining, and dispute resolution processes.

Structure and Governance

This working group was assigned the task of identifying an effective organizational structure for Ontario's future system of pre-hospital care. It was comprised of representatives from ambulance operators, unions, the Ministry of Health, and Management Board of Cabinet.

Everyone concerned knew that the issue of structure and governance was the area where consensus would be most difficult. For this reason, I want to go into some detail in describing the process adopted and information gathered, by this working group.

All members of the working group agreed immediately that the status quo was not an option. Deliberations focused on models proposed by the Ontario Ambulance Operators Association (OAOA), the unions and, at my request, the Ministry of Health.

The models were assessed according to a variety of criteria developed by the steering committee and the working group. These include

- quality assurance and financial control mechanisms;
- ability to provide uniform standards while respecting local needs;
- regulatory structure;
- treatment of specific services, eg, hospital, private, etc.;
- career mobility;
- treatment of various stakeholders; and
- cost implications.

They were also assessed in light of the results from the comparative review of emergency health systems in other jurisdictions.

The group met with Bob Scott, a former ambulance operator, to discuss the rationalization experience of the system in the late 1960's/early 1970's. It also met with Don McDermott, executive director of Sioux Lookout District Health Centre, and representative of the Ontario Hospital Association, Regional Council #12, to discuss concerns of northern hospital-based ambulance services.

I also requested that an informal survey of hospital-based services be conducted by Eric Barton, an OAOA representative on the committee who is from a hospital-based service. The survey indicated that the majority of hospitals were interested in continuing to provide ambulance services, but that they also felt improvements were necessary in funding, staffing and training issues.

Because the emergency health systems in Quebec and British Columbia were identified by the operators and the unions, respectively, as models that closely resembled their proposals, the working group and the steering committee met with management and union representatives from both of these systems.

The OAOA Model

The Ontario Ambulance Operators' Association argues that if independent operators are to remain in the industry, the system must be restructured to remove the operators from the effects of the ruling that has resulted in the designation of Crown agents.

The OAOA model involves divestment of ministry-run services and dispatch operations to the independent operators, as well as purchase of vehicles and equipment by the operators. It envisions the creation of an Emergency Medical Service (EMS) Board of Administration to provide overall administration of the emergency health system. Comprised of representatives of government, business, labour, medicine and the public, all appointed by the Minister of Health, the board would provide financial control, develop licensing regulations, review legislation and regulations and provide advice to the Minister.

The OAOA would be given legislative authority to serve as the Licensee's Association. This body would represent licensed operators, conduct accreditation of licensees and provide support services, including management training and group purchasing power. An EMS Operation Review Board established by legislation, and comprised of members nominated by the Board of Administration and the Licensees Association would provide quality assurance, investigate complaints and register and licence all ambulance and dispatch services.

The OAOA emphasizes that "greater flexibility and independence from the government must be realized in order to allow for optimum function. The government must continue to legislate and monitor, but must now help to create an environment where service provision can be achieved by independent providers, according to predefined quality and standards."

The Unions' Model

The unions' proposal states that a centralized, single agency is the only structure that can provide equitable and effective service to the geographically diverse communities of the province. This organization would achieve uniformity of service, respond to the implications of the McKechnie

ruling, and avoid the administrative duplication that would occur if ambulance services were provided by a series of distinct and quasi-autonomous operations.

The unions' model proposes a public commission, to deliver all ambulance and dispatch services. It would be appointed by, responsible to and funded by the provincial government. The proposal notes that this model is in keeping with the tradition of health care being a provincial responsibility, that it avoids an expansion of the bureaucracy and removes the service from political interference.

Ambulance services would be rationalized where appropriate; others would stay at existing locations. Current operators would be given the opportunity to become managers in the new system.

Existing bargaining units of the three major unions would be maintained. However, unions would function as a council for the purposes of collective bargaining.

The "Incremental Change" Model

The third model, developed by the Ministry of Health, at my request, is an attempt to define a system that involves the least amount of change required to address the McKechnie ruling. It proposes that ambulance services be provided through service agreements between operators and either the ministry or a commission. Operators would be the single source for the first contract and would thereafter respond to a proposal call process.

Under this structure, employees of non-ministry services would remain employees of their respective services. Nonetheless, centralized collective bargaining would be an integral component of this model, encompassing all ambulance services and unions across the province.

The Quebec Model

We met with Mario Cotton, president and Lloyd Leger, vice-president health and safety of the union representing the majority of ambulance workers in Quebec, Rassemblement des employes techniciens-ambulanciers du Quebec (R.E.T.A.Q.); Bernard Lefebvre, special assistant to the president of Urgent Santé, the Crown corporation that provides ambulance services in the Montreal region; and with representatives of the Quebec Ambulance Operators Association, Mr. Claude LaRose, also an operator, and Gille Ricard, staff of the association.

It could be said that Quebec has two systems of ambulance operation: the one in Montreal and the one operating in the rest of the province.

Prior to 1981, ambulance services in Quebec were entirely private, with minimal government involvement. In 1981 the government gave the Montreal Regional Council of health and social

services responsibility for coordination of emergency health services. Urgent Santé was created to provide call taking and dispatch, coordinate patient transfer services and coordinate emergency wards. Urgent Santé negotiated a central contract with the 26 operators in the region for provision of ambulance services.

In the following years ambulance attendants in the Montreal region were organized by R.E.T.A.Q. The union's attempts to negotiate a central agreement with the operators resulted in a government-imposed central agreement in 1984.

Legislation introducing the current rules governing ambulance services in the Province of Quebec was passed in 1988. Bill 34 required every health and social services regional council to prepare an ambulance services coordination plan, detailing dispatch, service provision, evaluation and control for approval by the Minister.

The councils negotiate contracts with service providers in their region, utilizing a standard contract that has been developed jointly by the Ministry of Health and the Quebec Ambulance Operators Association. Ambulance companies under contract must provide continuous service to specific zones. The contract outlines the responsibilities of the provincial Department of Health and Social Services (developing ambulance service policies); the council (application of the policies); and the company (compliance with the policy within a reasonable time). The contract also specifies that the council shall not intervene in the management of the company and the company shall not sign any collective agreement that has not been approved by the Department of Health and Social Services.

The contract outlines in detail the operational responsibilities of ambulance companies. These include staffing, scheduling, insurance, communications, billing and collecting of all amounts attributable to patient transportation, monitoring, administration and reporting.

The contract provides for two budgets, one for operations and one for wages and benefits. The operating budget allocation is equal to the difference between revenues from patient fees and operating costs. It is established in part on certain fixed costs, including vehicles, and medical and communications equipment. It also provides for payment of profit and management fees.

The wages and benefits budget is established with the company on the basis of negotiated wage rates for hours paid at full-time for service and standby, with an average rate for benefits of 35 per cent, subject to reconciliation.

The contract also includes a dispute resolution procedure with an option for mediation and ultimate recourse to arbitration, paid equally by the parties to the dispute.

Attendants outside of the Montreal region are employed by the operators. A provincial collective agreement was negotiated in 1988, between the government, R.E.T.A.Q. and the ambulance operators association. As a result of Bill 34, the Conference of Regional Councils is now also a party to negotiations.

Bill 34 also provided for the transformation of Urgent Santé into a Crown corporation, no longer under the mandate of the Regional Council. The new corporation remained responsible for the organization and coordination of ambulance services in the Metro Montreal region, providing dispatch, ambulance and medical services. In addition, ambulance technicians employed by owners in the Montreal region were to become employees of the corporation. Ambulance technicians in the Montreal region had earlier formed a cooperative and bought out the private ambulance operators. Due to the bankruptcy of the cooperative, the corporation is now in the process of purchasing its assets.

Ambulance attendants in the Montreal region are required to have 336 hours of training; outside of Montreal, they are required to have only 150 hours.

The representatives from R.E.T.A.Q. stated that "there is no system in Quebec"; that the province is still at the study phase. The union is concerned that private operators in the system represent an unnecessary additional force; that they provide no benefit administratively or in terms of service quality. The union is pushing for a state-run system, but advocates worker cooperatives as an intermediate step to improved standards and stability.

On the other hand, the Quebec Ambulance Operators' Association argues that its members provide cost-effective and high quality service. Their claim is buttressed by results of an 1990 opinion survey indicating overwhelming public satisfaction (83%) with the ambulance service.

The British Columbia Model

We met with Nick Haazen, executive director of the British Columbia Ambulance Service and Kevin Galichon, president of the union local representing ambulance workers in the province, the Canadian Union of Public Employees, Local 873.

Prior to 1974, ambulance services in British Columbia were provided by a range of private firms, all operating without government involvement. In July 1974, as a result of a provincial government review of pre-hospital care, the Emergency Health Services Commission was formed as an agent of the Crown responsible to the Ministry of Health.

Since its formation, the commission has amalgamated most ambulance services in the province under one management structure, although fire departments are still responsible for providing ambulance services in three communities. Most owner-operators became managers in the organization.

The commission provides land and air ambulance and dispatch functions, medical control, inspection, administrative and support services and paramedic training through five directors reporting to an Executive Director.

The commission purchases chassis and builds its own ambulance vehicles. We were told that

this part of the operation was examined by the Social Credit government for privatization potential, but the study concluded that the private sector could not do the work as inexpensively.

It has an ongoing training contract with the Justice Institute, which also trains fire and police personnel. Academic training is blended with practical experience.

Minimum entry requirements for employment and Emergency Medical Assistant (E.M.A.) training are Grade 12 and an Industrial First Aid Certificate. This entitles an individual to part time employment with the commission and training as an E.M.A I. These two levels amount to 150 hours of training. Certification as an E.M.A. II is required for full time employment. Applicants must have one year of service, have handled 25 calls as an E.M.A. I and pass a pre-entry exam. This level involves 240 hours of training. The commission pays wages, meals and accommodation for employees receiving EMA II and higher levels of training, subject to a limited annual number of training opportunities.

There are no volunteers. Part-timers receive four hours' pay for each call but get no pay for being on stand-by. There will be wage parity between part time and full time hourly rates as of January 1992.

Out of 180 ambulance stations, about 15 have staff trained in Advanced Life Support procedures. ALS expansion is based on call volume and patient needs, indicated by the types of calls being done.

Commission employees are members of the Canadian Union of Public Employees, Local 873. The government is directly involved in collective agreement negotiations. Commission workers have full rights to strike, but the right has never been exercised. Both management and union representatives expressed a preference for the right to strike. The management representative noted that with an arbitrated settlement, decision-making is put in the hands of people with limited knowledge of the system.

Both the union and management representatives expressed a great deal of satisfaction with this model. They agree that the service's simple structure, strong esprit de corps, and the ability of the union and management to work together have resulted in a well run service with high standards and relatively conflict-free labour/management relations.

Comparative Review of other Jurisdictions

To further assist its deliberations on structure and governance of emergency health services, the review commissioned a comparative survey of organizational structures in other jurisdictions. Prepared by Katherine A. Graham, Management and Research Consultant, the report examined nine Canadian and seven American jurisdictions, as well as systems in France, the United Kingdom, Germany, Italy, Sweden and New Zealand.

Professor Graham identified current trends associated with the structure and governance of emergency health services in the jurisdictions examined, described generic organizational models and attempted to evaluate the models using criteria selected after discussion with the review.

The study identified twelve major trends:

1. **The system of governance for emergency health services is in transition in many jurisdictions.** Many jurisdictions in Canada and abroad have recently evaluated and/or anticipate changes to the organization of their emergency health systems.

2. **There is a trend to increasing standards and increasing the role of central government in setting those standards.** There is concern regarding minimum standards for training and qualifications of EHS personnel, for vehicles and for the organization and delivery of ambulance services.

3. **There is concern about the issue of universal access to service.** This concern focuses on the feasibility of achieving the goal that all citizens of a jurisdiction should have the same level of service, given the remote parts of some jurisdictions studied and the economics of providing service to these areas. The general response has been to adopt different approaches to service delivery and standards of coverage for urban and rural areas.

4. **Hard trade-offs are being made between increasing standards and the need to rely on volunteers.** Many jurisdictions rely to some extent on volunteers. Desires to increase the basic qualifications and improve training come in conflict with the fact that volunteers may be increasingly hard to attract. Potential volunteers can be deterred by more onerous standards, perceived risks of the job, lack of remuneration, and changing patterns of work.

5. **There is increased emphasis on cost accountability by those delivering services.** The trend toward centralization has been associated with concern about increasing accountability for the costs of services provided, as well as concern about standards of service.

6. **There is a significant trend to create regulatory or advisory boards to oversee emergency health services.** Most North American jurisdictions reviewed have established or are establishing a board structure to oversee emergency health services. Some are at the provincial or state level; others are at both provincial and local levels. Central boards are used for a variety of functions, including planning and coordination, monitoring or overseeing service delivery and advising the province or state on directions the service should take.

7. **The extent to which emergency health services can/should be integrated with other emergency services is under debate. Generally, greater integration is seen as**

desirable. The extent to which integration can be achieved appears to depend, in part, on whether certain organizational "building blocks" are in place, for example 911 or some other form of integrated dispatch.

8. **There is a trend to more centralized dispatch.** This takes two forms. One is the rise of 911 systems, to coordinate dispatch of emergency health services with other emergency response systems. The other is the development of centralized dispatch for emergency health services with a central organization.

9. **The method of dealing with routine transfers is a matter of concern.** In every jurisdiction studied, routine transfers make up the majority of ambulance "trips". In urban areas, the high volume of transfers and the implications for equipment, dispatch and deployment of vehicles and staff are of concern.

10. **Employee recruitment and career development are seen as important issues: however, there are no solutions.** There is a concern about on-going training and career development of paid service personnel. There is no agreement on the level of training required beyond Basic Life Support. Few ideas are offered to the problem of career blockage for attendants.

11. **Few formal systems for dealing with public complaints exist.** Despite the number and variety of boards being established to oversee emergency health services, no jurisdiction has created or vested a board with responsibility for complaints or advocacy.

12. **When emergency health services systems are reformed, there is a trend to "grandfather" existing services.** When change does occur, implementation tends to be gradual. For example, after 17 years, three fire departments in British Columbia still provide emergency health services on contract.

The study outlines five organizational models based on the data received from the various jurisdictions.

1. **A Totally Public System**

The provincial or state or national government has direct control over policy, management and delivery of emergency health services. All emergency health services staff are employees of the central authority and all equipment and other resources used are state assets and their acquisition and deployment is subject to central policy and control. The jurisdictions which most closely resemble this model are British Columbia, Sweden and the United Kingdom.

2. **A Municipal Model**

The central authority retains control for regulatory standards and determination of budgets or financial formula and responsibility for service management and delivery is divested to regional boards that may be coterminous with municipalities. Regional boards may deliver services directly, contract with other parties, or both. Jurisdictions that resemble this model include Alberta, Saskatchewan and Quebec.

3. **A Contract Model**

The central authority retains control over regulatory functions and contracts with individual providers or third parties for delivery of emergency health services. Nova Scotia, Prince Edward Island, Pennsylvania and Washington have emergency health systems that resemble this model.

4. **Central Regulation/Eclectic Delivery.**

Standards for emergency health services are embodied in legislation and services are provided by private operators, hospital, municipalities, volunteers or some other agent. The level of government funding for service delivery varies. Manitoba, Illinois, Massachusetts, Michigan and New York have systems resembling this model.

5. **A Laissez-Faire Model**

There is little or no regulation by the central authority. If there are standards, adherence to them by providers is voluntary and unsupervised. Methods of service provision vary as do costs and the extent to which costs are borne by users. New Brunswick and Ohio have historically adopted this approach but both are moving toward a regulatory model.

The report assessed the model according to criteria developed after discussion with the review. The criteria are

* **consistency** - the extent to which a particular system induces a uniform standard of service for the entire population;

* **public responsiveness** - the extent to which a particular model is adaptive to the needs of different segments of the population and the extent to which it involves the public in the determination of those needs;

* **integration** - the extent to which a particular approach fosters the coordination or integration of emergency health services with other emergency services;

* **human resource management** - the extent to which a particular model introduces the appropriate deployment of personnel and addresses the need for their training and development;

* **cost consciousness** - the extent to which a particular approach permits the cost implications of providing emergency health services to different segments of the population to become transparent and the extent to which it induces the highest level of services with the least amount of expenditure.

The study found that the models that exhibit the most positive aspects were the public and municipal models.

The comparative review provides a useful point of comparison for the situation in Ontario. There is striking similarity between the issues identified in the terms of reference for the Emergency Medical Services Review and those identified in the comparative review as common trends. Our system also looks very good in comparison to other jurisdictions. It is interesting to note that many North American systems are moving to adopt features that have long characterized Ontario's system, for example, a high degree of central regulation.

I think that the public and municipal models, identified as having the most positive aspects, are of equal merit. It is probably true that a public model will provide a higher minimum standard of service across the province, at a potentially higher cost. Other than that the major point of comparison seems to be the organizational model itself, involving a decision on whether emergency health services should be provided by the provincial government or devolved to the municipal level.

The three models proposed to the review are consistent with what Professor Graham identifies as better models. It is very clear what kind of model Ontario does not want. That is, a de-regulated, laissez-faire style of operation. Fortunately, that kind of system no longer seems to hold favour in any jurisdiction.

CHAPTER 2

RATIONALE AND RECOMMENDATIONS

INTRODUCTION

This chapter is divided into four sections corresponding to the broad mandates given the review: structure and governance, labour management relations, service issues, and staffing, training and career development. Each section intersperses the rationale and the formal recommendations (presented in italics) for the issue at hand. Virtually all the discussion and recommendations concerning structure and governance represent my view. The labour management relations recommendations are largely a product of my proposed structure, but with one exception, are consistent with general principles agreed to by the entire steering committee. In contrast, the final two sections on services and staffing/training issues are complete consensus documents from the steering committee.

A. STRUCTURE AND GOVERNANCE

General Principles

It was obvious from the beginning that reaching agreement within the steering committee about the structure and governance of the ambulance industry would be extremely unlikely. Nonetheless, the steering committee did develop a consensus about general principles which should apply to whatever specific system of governance I eventually proposed. These four recommendations are listed below.

A1. Regardless of the future structure of the system, substandard operations should not be part of the service. There is need for development of criteria and methods of evaluation that utilize an educational approach, wherein necessary changes are discussed with the operator/manager. Operators, who disagree with the findings of an evaluation, should have the right to appeal through the existing Health Facilities Appeal Board.

A2. Where it is appropriate to tier the ambulance system into emergency and non-emergency services, this should be accomplished to ensure that the non-emergency service continues as an important component of the emergency health care system, which would be operated within the system.

A3. Most individuals currently working within the emergency health care system, regardless of where they work and what they do, are dedicated and committed to a system that consistently delivers a high standard of care. Regardless of the future structure, all competent and qualified individuals should be encouraged to work within the new system.

A4. The new system must be responsive and accountable to local community needs and simultaneously, maintain uniformly high standards. To enhance this capability, there should be an advisory committee structure that is broadly representative of those working within the system, as well as consumers, that will have the broad mandate of ensuring that the system delivers high quality emergency health care in a way that respects community needs.

Let me begin the discussion of alternative structures for the ambulance industry by addressing the OAOA position. I find many of their arguments difficult to accept. First, is the requirement that the provincial government divest its dispatch, land and air ambulance services. Privatizing the health care system goes against the stated policies of this government as well as its predecessors. In their defense, the OAOA states that this divestment could be local public authorities, who would either provide the service directly or contract with an organization to run it. While divestment to a different public organization may be more palatable philosophically, I see no benefits from such a move. More likely, the province would be sacrificing control over service quality without any reduction in its financial responsibility over service costs.

The OAOA argues that its structure would increase operational efficiency. While it is true that private operators have lower average costs at present, virtually all of this difference is accounted for by higher wages in the ministry services. Everyone concedes that an inevitable consequence of the McKechnie Ambulance decision is compensation parity throughout the ambulance industry in a fairly short time frame, thus negating the cost advantage. Their proposal keeps decisions about the number of staff and compensation out of the hands of individual service providers, with all labour costs being passed through entirely to the province. That means 80% of ambulance costs are out of the local operators control.

The operators would buy their own "tools', subject to externally set standards. In particular, they would not be allowed to modify the number of ambulances required in a specific territory. It is difficult to fathom how individual operators or even a consortium of OAOA members could negotiate better prices on ambulances and other equipment, than the Province of Ontario. The only way equipment costs could be lower is if the goods were lower in quality, or not as well maintained. The same argument applies to rental of space. In the end whatever economies can be generated in terms of "entrepreneurship", refer to probably less than 5% of the budget. I do not believe the OAOA model could generate lower costs than the alternative models, without reducing the current high quality of service.

In fairness, the OAOA structure does allow for greater local input into ambulance operations than the existing system. Unfortunately, the flip side of greater decentralized decision making is more difficulty in assuring minimum standards, because of greater monitoring costs. I believe there exist ways to assure local input into a more centralized structure of service delivery, through the district health councils.

The incremental change model, developed at my request, maintains much of the status quo in the ambulance industry, while attempting to alleviate three current problems. First, centralized bargaining resolves the legal problems associated with the McKechnie decision, and, simultaneously provides a forum for the development of more comparable compensation and greater job mobility across the province. Secondly, licenses would be turned into renewable service contracts, making it easier to remove independent operators who have not provided adequate service. Finally, the move from branch status within the Ministry of Health to a Crown agency would reduce many of the government-wide regulations on construction and purchasing which often delay changes in ambulance service levels due to greater call volume.

I believe that features of this model are valuable in allowing for the transition to the ideal long term structure of the ambulance service.

I am generally more enthusiastic about the unions' proposal for a province-wide system, under the auspices of a Crown agency. Creation of a province-wide public entity responsible to and funded by the Ministry of Health is entirely consistent with this government's broad initiatives aimed at protecting high quality social services, ie. social policy should not be delivered by private profit-based organizations.

At an operational level, a commission would have a clear mandate to develop and ensure minimum standards of service throughout the province and could still allow for local input through district health councils. Standards would be easier to enforce because their would be clear lines of authority and communication within the organization would be more direct. Irregularities in service delivery or financial accountability would be uncovered more easily under this highly visible organizational structure. Likewise, the public would find the transparent structure more accessible and accountable than the current or alternative systems. Finally, the commission model could eliminate administrative duplication.

Employees would benefit from greater job mobility and potentially longer careers, resulting from the ability to transfer geographically or to less physically taxing positions within the commission. These steps toward career development would increase morale and the sense of professionalism, ultimately leading to higher quality service being provided to the public.

The Emergency Health Services Commission

I believe that the model for a Crown agency represents the best long term option for the ambulance service. The phrase, "long term" is used advisedly, as it took the British Columbia system 18 years (1974-1992) to fully integrate existing ambulance services into its commission.

In a labour relations environment, unions invariably demand that organizational changes which will generate need for fewer employees (whether it is related to 'down-sizing' or technological change) be implemented slowly in order to guarantee existing workers their jobs. In my view, the concept of change through attrition should also apply in this case. The current providers of ambulance services have generally been doing an exemplary job, whether it be private firms, the ministry, hospitals, municipalities or volunteers. In terms of fairness, the organizations and individuals involved in them should be insulated as much as possible, from the dislocations associated with a change from the current structure to a provincial Emergency Health Service Commission.

A5. The Ambulance Act should be amended to create the Emergency Health Services (EHS) Commission which would eventually become the major provider of air and land ambulance services, including dispatch, in the province. The EHS Commission would be established as a type 3 Crown agency, making it totally distinct from the Ontario public service. It would report

to the Minister of Health and continue to be funded by the province.

A6. The EHS Commission would be composed of three senior officials from the Ministry of Health (ie. the Assistant Deputy Ministers of Community Health, Institutional Health and Consumer Health and Planning), one from the medical profession and one from the community at large.

The commission would consist of all current ministry employees involved in providing ambulance services. As these individuals would no longer be Ontario public service employees, some 'grandparenting' of pension and job bidding rights must be provided, to smooth the adjustment. Current managerial personnel in the EHS Branch would assume a concomitant role in the new organization. The costs of this initial restructuring would be minimal. Through time, the commission would expand its direct jurisdiction over independent ambulance services.

A7. The new EHS Commission would be the employer of all those working in the five air ambulance services, the Central Ambulance Communications Centres, the nine ministry-run services, and the Emergency Health Services Branch of the Ministry of Health. The Director of the Emergency Health Services Branch would report directly to the commission.

A8. The existing regional branch structure would be expanded upon in the new EHS Commission to allow for greater community involvement (through district health councils) into ambulance service issues.

Given the diversity among types of service providers, implementation of the EHS Commission would vary. Nonetheless, there should be general rules concerning the transfer of any service to the commission, namely that all employees and managers would become employees of the EHS Commission and that the commission should compensate an operator fairly for any real assets purchased or leased from the operator.

A9. If a service is transferred from an independent operator to the EHS Commission, it is understood that the all competent and qualified employees and managers of the independent service would receive equivalent positions as employees or supervisory personnel with the commission. In addition, the commission must provide fair compensation for any assets purchased or leased from the operator, at the time of transfer. The operator should be allowed to appeal the commission's financial offer for assets to the Health Facilities Appeal Board.

Private Sector Operators

Existing ambulance licenses would be terminated and, in their place, independent operators would be entitled to renewable service contracts, based on acceptable performance. These contracts would require operators to pay wage and other acceptable expenditures first, and subsequently bill the commission. This approach ensures greater financial accountability of

ambulance operators[1], and because, the EHS Commission would be a Crown agency, it is not bound by the Ministry of Health policy prohibiting sole source contracting for more than seven years.

A10. *The Ambulance Act should be amended to revoke existing ambulance licenses. The EHS Commission would then issue three year service contracts to former licence holders. Renewal of the contract would be subject to acceptable service provision in the preceding period. Renewals would not be unreasonably denied, and would be reviewable by the Health Facilities Appeal Board, or an equivalent arbitration process.*

These changes do leave one of the major current stakeholders, licensed private operators, worse off. Whether or not individual operators purchased their license (most did not), that license clearly has a real market value. Under my proposal, that value would be substantially reduced. With few exceptions, private operators have worked hard in their communities and have built up considerable goodwill. Although there have not been many sales in the last year, it is generally acknowledged that licenses have traded in the market place for 2.5 to 3.5 times the value of the annual management compensation package (MCP).[2]

I believe, that in the interest of fairness, private operators who do not want to continue in business under the commission-based regime should be compensated by a payment of three times annual MCP. Those operators who want to give the new system a try would be issued a three year contract. If, after the three year period, the operator qualifies for renewal (based on acceptable performance), but would rather cede the service to the commission, he/she should be compensated at 1.5 times the MCP. Any operator who does renew must be assumed to want to stay in business and does not have a claim on compensation. At the same time there should be some inducement for operators to eventually cede their territory to the commission, so I propose that upon any subsequent renewal, should the private contractor decide to surrender the contract to the commission, that the operator be paid 0.5 times the MCP (akin to six months severance). At such time, all employees would become employees of the EHS Commission and, where feasible, existing operators would become supervisory personnel of the commission.

Some private operators would not consider exchanging their entrepreneurial role for that of management employee, while in rare situations it may be impossible to provide the former operator a comparable position. Even in these cases, I would argue that the proposed compensation is extremely gracious.

A11. *If a private licensed operator would rather not continue to provide ambulance service under a contract basis, the operator should receive compensation equal to three times the current*

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[1] There are a few operators who have not lived up to their obligations in terms of service and financial accountability, and the current system of licensing has made it extremely difficult to rectify their behaviour.

[2] The range in value depended primarily on whether a service's call volume was close to the next higher payment level in the MCP step function.

annual management compensation plan (MCP). If, after a single three year contract, an operator, who is eligible for renewal based on acceptable service, agrees not to renew, he/she should be paid compensation equal to 1.5 times the current annual MCP. If, after any subsequent contract, an operator, who is eligible for renewal decides to cede the service to the commission, he/she should be paid compensation equal to .5 times the current annual MCP.

There are currently four private firms which operate under a standard service contract. These operators became involved in ambulance service under a very different set of rules. No commitments beyond the life of the contracts are made, except that these companies would be allowed to submit a proposal to provide the service in the future. These services should be taken over by the commission, at the conclusion of the existing contracts. At such time, employees and the contractor would become employees of the commission.

A12. When the four existing service contracts to provide ambulance service expire, the commission should take over operations in that area.

Public Sector Operators

Hospital based ambulance services are a different situation, being public sector institutions. The potential disruptions to individuals would be minimal, at best. Most hospitals are not eligible for the management compensation plan, and a number have stated that operating the ambulance service actually costs the hospital money. A common reason given by hospitals for running the service is that it facilitates coordination among the various medical departments. While this is probably true, there is no indication that the quality suffers when ambulance services are provided by other modes. At the same time, the unions have complained that ambulance officers have been required to work as orderlies, when waiting to respond to calls. If anything, such requirements decrease effectiveness in responding to emergency calls.

I believe that once the commission is established, it should take over hospital based ambulance services, on a staggered basis. Those hospitals most willing to hand over ownership of the service would do so, instead of applying for a service contract. Those hospitals wanting to retain the service would be offered the standard three year service contract. Hospitals could cede the service at the end of the period, or request a renewal for a final three years. Following the second three year renewal, all remaining hospital ambulance services would be ceded to the commission.

It must be emphasized that the operations of many hospital services would be virtually unchanged as a result of the commission's takeover. Members of the public might not be aware of the change. Most services could still be located at the hospital, and instead of saying "ABC Hospital Service", all insignia would say "ABC Hospital Branch". The hospital would charge the commission rent for the space, and could potentially supply other administrative services on a fee basis. There is no reason to believe hospitals would be worse off financially and many (who say they currently lose money) could be better off. All those working in the hospital

ambulance unit, would merely become employed by a different public entity, the EHS Commission. These reasons, combined with the reality that hospitals are ultimately funded by the public purse, make it clear to me that financial compensation to hospitals for ceding their license to the commission would be inappropriate.

A13. *The EHS Commission should take over hospital based ambulance services on a staggered basis. Individual hospitals should be given the option of relinquishing the service immediately, or following up to two three-year service contracts. Where feasible, the commission should attempt to reach an agreement with the hospital to keep the ambulance service located on the hospital premises.*

There is a tradition in Ontario to allow municipalities to opt out of police services delivered provincially (the OPP) and establish their own local police department. The rationale has been that a community should be entitled to offer a level of policing beyond the basic minimum and catered to local demands for service, provided the local taxpayers are prepared to shoulder the burden. I see no difficulty in extending this concept to ambulance service, because the municipal jurisdiction would be both politically and financially accountable. The current financial arrangement for ambulance services in Metropolitan Toronto is consistent with the policing models in that 75% of approved expenditures are eligible for reimbursement from the ministry. Other municipalities should be allowed the same degree of local control as Metro Toronto, provided that they share the cost. In particular, a municipal-based ambulance service separate from the EHS Commission, would be predicated on local funds making up the difference between actual expenditure and the commission's 75% reimbursement of approved expenditures.

There are currently three municipal services where the ministry pays all expenses. If these municipalities are not interested in cost sharing based on the Metro model, they should be required to cede the services to the commission. If any of the municipalities do not want to give up the ambulance service immediately, they should be allowed to continue operation under service contracts with the existing financial arrangements for up to six years, similar to current hospital providers.

A14. *Municipalities should be allowed to opt out of the EHS Commission's operation of ambulance services, provided that the municipality would be reimbursed for only 75% of approved expenditures. The municipality would be expected to pay the remaining costs of providing its own ambulance services.*

A15. *Existing municipal ambulance services which are not willing to pay their share of operational costs, should be required to relinquish the service under the same terms as hospital services.*

Volunteer Operations

Volunteer services play an important role in the current provision of ambulance services, particularly in Northern areas of the province. I believe that volunteers must be maintained within the commission system, as they are a source of pride to the communities they come from, are the only feasible way to provide service in areas with extremely low call volume, and, in some cases, save taxpayers money.[3]

The steering committee agrees that true volunteers have a role in the emergency health system. Nonetheless, it must be acknowledged that there are two kinds of volunteers: those who are employed full time elsewhere, and for whom this is community service; and those who depend on this activity for income and anticipate it leading to permanent employment. Unions have expressed concerns that these volunteers are not sufficiently well trained and, in some cases, are really poorly paid part time ambulance officers. These concerns are legitimate, but can be addressed within the context of voluntary service providers.

First, there should be a standard compensation policy for volunteer ambulance officers, across the province. In theory, the compensation is to reimburse individuals for the 'out of pocket' costs associated with volunteering. Yet some volunteers receive a monthly stipend, while others are paid on a per call basis. Ideally, the uniform payment policy would relate to the time spent on standby, in training, and responding to calls.

In addition, the EHS Commission should plough back a portion of the savings associated with volunteers, into training for these individuals. Assuming these steps are taken, I foresee no difficulties with the coexistence of paid and voluntary providers, under renewable volunteer service contracts.

A16. Licensed volunteer services should be allowed to continue providing ambulance service, through three year renewable contracts.

A17. The EHS Commission should develop a unified point system for remuneration of volunteers, similar to that utilized by volunteer fire departments.

A18. The EHS Commission should provide training programs for volunteers to increase skill levels.

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[3] It must also be noted that the same issues apply to volunteers working for hospital or other based services. In these cases the service is partially staffed by volunteers.

B. LABOUR/MANAGEMENT RELATIONS

The model for labour relations is largely determined by the proposed structure. Although the labour relations environment had to addressed in hypothetical terms, the steering committee was able to reach a consensus on almost all issues. The EHS Commission, as a type three Crown agency, would not be part of the public service, and would require legislative definition of bargaining units, bargaining structure and method of dispute resolution.

Bargaining Structure

The EHS Commission would be paying the entire compensation costs of all employees, whether they were initially working for the commission or an independent operator. Therefore the commission must have a direct responsibility in the negotiation of collective agreements.

At the very least, compensation must be determined at a central bargaining table, given the fiscal, and legal ramifications of the McKechnie decision. In the beginning, this would translate into a number of identical master agreements, one for commission employees proper, and a number for the independent operators in the system.[4]

There should be a single bargaining for ambulance officers and dispatchers, who are the sole financial responsibility of the commission. This principal bargaining unit would encompass approximately 3000 full-time and part-time employees. Volunteers, not being employees, would not be covered.

B1. *There should be a single province-wide bargaining unit for all ambulance officers (air and land) and dispatchers who are funded entirely by the EHS Commission. On the employee side, a single bargaining agent would be certified, following the certification rules outlined in the Ontario Labour Relations Act. The bargaining agent could potentially be a council of the existing unions, or an individual union. The employers would be represented by a coalition of the EHS Commission and the independent operators. Central bargaining would cover at least the major financial issues - wages and benefits. The parties would no doubt agree that some issues were better left for local bargaining, rather than being part of the master agreement.*

B2. *The administrative staff of the EHS Commission would not be part of the bargaining unit described above, but would be entitled to representation under the rules of the Ontario Labour Relations Act.*

At present, the only exception would be the Metro Toronto Ambulance service, which has substantial fiscal responsibility for wage settlements. Those workers should continue to bargain directly with their employer. If other municipalities eventually provide their own ambulance

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[4] The Ontario Colleges Collective Bargaining Act is similar in mandating a provincial bargaining unit, despite the existence of 22 separate community college employers.

service by sharing the cost, then their employees would be treated in a similar way.

B3. The Metropolitan Toronto Ambulance Service should be exempt from the provincial bargaining unit, allowing the parties to bargain directly. In the future, municipalities who provide service under a similar cost-sharing plan, would have their employees moved from the commission to the municipal jurisdiction, similar to Ontario's provincial/municipal policing model.

Dispute Resolution

It must be conceded that at least some ambulance services (responding to emergency calls) are essential to public safety. As such, a work stoppage by all ambulance employees would not be acceptable. At the same time, there is no enthusiasm among the various parties for interest arbitration as the collective bargaining dispute resolution process. It is generally accepted that arbitration inhibits the negotiation process because the parties are less likely to make concessions during direct bargaining, and reduces the accountability of the parties to their constituencies and the public. The preferred method of resolving bargaining disputes is a limited strike system, which would mean a suspension of all non-emergency transfers during a work stoppage.

B4. Prior to collective bargaining, the parties would be required to determine the proportion of the ambulance officers and dispatchers required to work in the event of a strike to guarantee that all emergency calls would be serviced. Any disagreement as to the appropriate numbers to be designated essential, and unable to strike, would be submitted for resolution to the Ontario Labour Relations Board. Following the designation process, if the union felt that a strike was not feasible because the overwhelming majority of positions were designated as essential, then the union would have the right to opt for interest arbitration.

The limited-strike dispute resolution model is without precedent in Ontario, although it has been used in other provinces and the Federal government. For that reason, implementation of this model may be difficult.

B5. If the only feasible alternatives for dispute resolution are an unlimited strike or interest arbitration, interest arbitration should be used, as is the case with firefighters and police.[5]

The issue of essentiality does not evaporate, when one crosses the boundaries of Metropolitan Toronto (or any future municipal service). Although there has been a concerted effort not to intrude on the operations of the Metro Toronto service, it is unavoidable when public safety is involved.

B6. Regardless of the specific bargaining unit(s) that ambulance officers and dispatchers belong

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[5] This recommendation is not supported by the labour representative to the steering committee, who would choose the unlimited right to strike.

to in Metropolitan Toronto or other future cost-sharing municipal services, the parties must agree on procedures for maintaining sufficient staff to respond to emergency ambulance calls, in the event of a strike by other bargaining unit members.

Scope of Bargaining

In some public sector jurisdictions, the range of issues which are subject to collective bargaining is limited to exclude issues of public policy. There are no a priori reasons to limit the scope of bargaining in the ambulance service. Nonetheless, it must be acknowledged that the pension issue is extremely complex, given the variety of pension plans among current ministry and independent operators. It is possible that the parties might decide to allow employees to remain in their existing plans, which would mean that some pension issues for some employees could not be bargainable (ie. the Ontario Public Service Pension could not be negotiated at the centralized ambulance bargaining table).

B7. *The scope of bargaining for the ambulance industry should be identical to the private sector.*

Grievance Arbitration

Effective administration of collective agreements is an important part of a healthy labour relations environment. Past experience has indicated that ministry services faced greater delays with the public sector Grievance Settlement Board (GSB) than independent operators who rely on private sector arbitration. By the same token, effective grievance arbitration generates joint benefits, so it is reasonable to expect both parties to share the cost. Unlike the private sector, unions do not have to pay half the costs of the GSB. Timelier access and fairer distribution of costs would be assured by adopting the private sector arbitration model.

B8. *Arbitration of rights disputes should be governed by the rules covering the private sector embodied in the Ontario Labour Relations Act.*

C. SERVICE ISSUES

Underlying Principles

The steering committee endorses the underlying principles adopted by the service issues working group that Ontario's emergency health service must be:

- accessible and provide equitable, patient-centred treatment and care;
- responsive to community, regional and provincial needs;
- accountable to the public and the patient for definition and implementation of roles and responsibilities;
- accountable to the public and the patient for efficient, effective use of resources and the provision of quality services;
- compatible with other providers of health care, other institutions and other first responders;
- guided by legislation that enables it to define and carry out its functions in relation to its community, its mission, tradition and values and the policies and guidelines of the Ministry of Health.

Access Issues

Any discussion of accessibility and equity of emergency health services in this province is immediately complicated by the realities of Ontario's vast geographic area, varying population densities and challenging weather conditions. It quickly becomes apparent that it is not possible to provide to individuals living in remote or rural communities the same response time, or range of services and in some areas, providers may not have the same level of training as those in more populated areas.

A service that is provided equitably should ensure that the primary components of the service are provided in a way that ensures patient care standards and is appropriate to the needs of the community and available funding.

A comprehensive emergency health system is comprised of the following key components: access to care, through 911 or other rapid access to dispatch, a standardized dispatch system, achievement of target response times, provision of effective Basic Life Support (BLS) services, and Advanced Life Support (ALS) services, where appropriate. Without rapid access to dispatch, there is no assurance of access to the other components of the system.

C1. *It is recommended that the entire province be covered by the 911 system, to ensure public access to rapid dispatch, and that this be mandated by legislation.*

C2. *The 911 system should be accessible to people who are hearing impaired.*

C3. *Consideration should be given to the concept of individual customer billing by the telephone carrier to finance the 911 project.*

C4. *Dispatching protocols should be designed and consistently monitored to deliver a multi-agency response as quickly as possible.*

C5. *The entire province should be covered by the Central Ambulance Communications Centre (CACC) system and this should be accomplished by 1998.*

C6. *All ambulance dispatchers should be trained to provide telephone instructions for cardio-pulmonary resuscitation (CPR), first aid and pre-arrival assistance, utilizing an approved priority medical dispatching system.*

C7. *The ministries of Health, Solicitor General and Transportation should jointly explore the possibility of strategically placed telephones on highways in rural and remote areas.*

C8. *The placement of hospital indicator signs should be reviewed by the Ministry of Health and Ministry of Transportation to ensure that the public is being directed to facilities with 24-hour emergency capacity, where there is a physician on site or on call 24 hours per day.*

At present, all CACC's use the same Priority Card Index for medical dispatch. This index has the potential to allocate resources inappropriately to Code 4's (the most urgent calls). A review of this system is currently underway.

C9. *The EHS branch should be encouraged to develop a pilot project, to explore alternative medical dispatch systems under controlled circumstances. The pilot project should include coaching of callers to provide initial first aid/CPR. There should be an evaluation and recommendations made by those involved in the pilot, as well as experts in standard medical priority dispatch, to determine whether the program should be implemented throughout the province, including Metro Toronto. Implementation should begin as soon as possible.*

Citizen CPR should be viewed as a key part of an effective, comprehensive BLS service. It is a critical factor in a successful emergency health service response to situations involving cardiac arrest. Research shows that citizen CPR is associated with improved chances of survival; it can 'buy time' for the patient until advanced life support arrives. Citizen CPR training is a pro-active, empowering approach consistent with current health policy.

C10. *An Ontario Heart and Stroke Foundation approved 'Heart Saver' course, or equivalent, and a standard first aid course should be a mandatory prerequisite to obtain a driver's license.*

C11. CPR training should be included in the Ontario high school curriculum.

C12. CPR and first aid training programs should be targeted towards groups who are likely to be exposed to situations requiring use of these skills, for example, families of heart patients, teachers, public transit workers and other employees working in areas where there are regularly large crowds.

Emergency Response Time

It is generally agreed that the goal of the emergency health system is to provide the fastest possible medical response to a patient, and to provide definitive care in the most rapid, effective and efficient manner possible. Because response time is such a critical factor in emergency situations, there should be a response time standard for emergency calls, to provide a minimum standard of quality as well as an ongoing measure of effectiveness and efficiency.

In establishing a response time standard, it must be emphasized that this is considered to be a minimum acceptable standard and that it should be continually evaluated and improved. It is recognized that the recommended standard is achievable with redeployment of existing resources.

In obtaining the response time standard in communities throughout Ontario, consideration will have to be given to appropriate siting and resourcing of ambulance bases.

The steering committee endorses the view of the service issues working group, **that it regards response time as the most crucial issue of its deliberations. It believes that response times must be met before the ministry contemplates any other emergency health service action in a particular area.**

C13. The province should adopt the following response time standard for all dispatched Code 4 calls:

- Response time is defined as the amount of time from receipt of call by dispatch until the ambulance crew arrives at the scene.

- The response time standard shall include the maximum CACC reaction time of one minute and the maximum crew reaction time of two minutes.

- The minimum acceptable target response time, from receipt of call, until arrival at scene, shall be eight minutes for large urban areas, 13 minutes for urban/suburban areas and 23 minutes for rural areas. Of all Code 4 calls, 90 per cent shall be serviced in less than 10 minutes in large urban centres, 20 minutes in urban/suburban centres and 30 minutes in rural areas. In remote or wilderness areas, where response times are contingent on the circumstances of the call, ongoing evaluation must be made of the service's capacity to respond to all contingencies.

C14. *Where standard minimum response times are not being met, the Ministry of Health should review its methods of station location, the need for satellite stations, as well as vehicle and staff deployment. Changes should be implemented to achieve minimum response time standards.*

C15. *The time of arrival at the patient's side should be recorded by ambulance attendants and be reported to CACC's. The information should be used in efforts to reduce response times.*

C16. *The Ministry of Health should approach the Ministry of Municipal Affairs and Housing to ensure that all municipalities make provision for ambulance bases in zoning and site developments.*

Tiered Response

Historically, fire, police and ambulance services have co-operated in the provision of assistance in situations requiring a medical emergency response. The basis for this kind of multi-agency response is the recognition that victims of cardiac arrest could be saved if organized basic emergency care providers reached the victim within 3 - 5 minutes and began cardio-pulmonary resuscitation (CPR).

In Ontario there are a variety of tiered response arrangements, with most communities having informal arrangements activated on an "as needed" basis.

At present, there is no generally recognized definition of tiered response, nor are there clear criteria or protocols for implementation of these agreements. Roles of participating agencies remain largely undefined. There are no standards for training and equipment and funding questions are unresolved.

Tiered response should be pursued more actively, where appropriate, and be based on the understanding that ambulance service is the primary medical prehospital care provider.

It is important to note that some agencies who could be involved in tiered response agreements are funded by and responsible to municipalities, for example, fire and police services. Other agencies are responsible to specific provincial government ministries. For this reason, tiered response agreements should be developed through discussion with municipalities and consultation with all agencies involved, including management and employee representatives.

C17. *Tiered response should be defined as a collaborative community emergency response between public safety agencies to assist with patient care. Patient care includes site preparation and assistance, safety, as well as medical care. The goal is to get a trained person to the patient as fast as possible. Collaboration is built on the recognition that the ambulance service has primary responsibility for prehospital patient care, fire services have primary responsibility for rescue and police have primary responsibility for scene and crowd control. Tiered responders may be ambulance, fire, police, first response teams, coast guard, Ministry of*

Natural Resources personnel, or other personnel as determined by a municipality or region.

C18. The development of tiered response agreements should be facilitated by regional ambulance offices, in collaboration with base hospitals. They would consult with municipalities and ensure that all relevant agencies were involved in the development of a tiered response agreement appropriate to the community's needs.

C19. When tiered response agreements are initiated, the question of liability must be dealt with.

C20. Those designated to be the first responders in a tiered response agreement - that is, the agency that arrives within the three - five minute response time required for cardiac arrest situations - should be trained in CPR, first aid and oxygen therapy.

C21. Upon arrival of the ambulance to the patient's side, the first responder should transfer responsibility for patient care to the ambulance officers.

C22. Tiered response agreements in any community should define appropriate roles for each agency in cases such as cardiac arrest, airway obstruction, respiratory arrest, haemorrhage, chest pain, violent and uncooperative patients, extrication, scene safety, disaster management, hazardous materials and access problems.

C23. The existing Public Services Liaison Committee should be expanded to include ambulance operator, consumer, medical and municipal representation. It should address matters such as the need for standardized dispatch protocols for tiered response, with an emphasis on ensuring appropriate utilization of resources for Code 4 calls; development of generic tiered response agreements and an orientation course; development of guidelines for implementation of fire fighter defibrillation programs, or other response agencies, where appropriate. It is the expectation of the steering committee that fire fighter defibrillation would be an exceptional occurrence, as the ambulance service has primary responsibility for patient care. Where fire fighter or other agency defibrillation programs are implemented, they must be implemented jointly with the ambulance service.

C24. All agencies should be encouraged to implement the federal government designated common radio channel for on-scene inter-agency communications.

C25. Tiered response agreements should be reviewed, evaluated and revised as necessary at regular intervals to ensure that the system is working effectively and meeting its stated goals.

C26. In communities that choose to implement fire fighter or other agency defibrillation, the Ministry of Health, through the base hospitals must provide standards, medical control and certification.

C27. The Ministry of Health should take a lead role in the development and coordination of patient care policy and guidelines, universal precautions for infectious disease, tiered response

orientation programs, joint training ventures for common skills and equipment, common data collection, and joint public relations and education ventures.

Advanced Life Support

Advanced Life Support (ALS) is the performance of delegated acts in the pre-hospital environment by paramedics certified by and operating under the supervision of a physician.

A number of ambulance services developed ALS programs in the 1970's with the support of local physicians. The scope of these programs varied according to local needs, with the most commonly-provided procedures being prehospital defibrillation, application of pneumatic anti-shock garments, and initiation of intravenous lines. One of the services provided a wide range of ALS procedures.

In the early 1980's the ministry placed a moratorium on further expansion of ALS programs. It developed a pilot paramedic program to examine training, legal and operational requirements and to determine human resource and cost implications of future expansion.

The pilot concluded that it was feasible to implement a range of paramedic programs throughout the province, but that such expansion could only be considered if it would not incur major additional staffing costs. It said there should be development and testing of some alternative paramedic service models in two large urban communities, one smaller urban community and in one or more rural areas. It also concluded that the pilots in Hamilton and Toronto should continue as ongoing programs and that the ad hoc programs which were implemented prior to the pilot should be reviewed, evaluated, and formally approved by the ministry.

There is a lack of sound scientific evidence showing significant reduction in morbidity and mortality as a result of any prehospital ALS intervention, other than rapid defibrillation, and then only when it is performed in a setting of rapid system access and early CPR administered by bystanders at the scene. Because of this, the only delegated medical act that has been widely introduced into the ambulance system is rapid defibrillation.

The steering committee has evaluated current ministry criteria for introduction of ALS procedures and recommends a number of changes.

***C28.** The first criteria for implementation of ALS programs must be that the ministry will establish base hospitals or associate base hospitals across the province by 1994, as per the current EHS Strategic Plan. This is a necessary prerequisite, to ensure ongoing medical control of the Advanced Life Support pre-hospital program. The base hospital program must be appropriately resourced and audited.*

***C29.** There is a need for a shared understanding and resolution within the EHS sector of the role of base hospitals. Base hospitals should be involved in the development, coordination and*

implementation of emergency health systems in their communities. The EHS branch should work with the Base Hospital Advisory Group, and representatives of ambulance operators and unions to prepare a document that defines the general role of base hospitals and permits specific roles to be worked out in individual contracts.

C30. The ministry currently requires that an ALS program proposal be endorsed by the district health council (DHC) and district and area EHS committees. The steering committee is concerned that at times DHC's and EHS committees may make decisions on ambulance services without direct involvement of individuals and organizations engaged in these services. To ensure broad-based representation in the ALS planning process:

a) Each Base Hospital Utilization Review Committee should have representation from ambulance service providers, with both management and elected worker representation;

b) The Base Hospital Utilization Review Committee should have formal, or at least, informal representation on district and area EHS committees;

c) District health councils should ensure that all appropriate parties, such as police services, fire fighters, ambulance operators, ambulance unions, base hospitals, etc. have been fully consulted when making decisions on emergency health service issues.

C31. The ministry currently requires that there be research evidence showing positive outcome on mortality before implementing an ALS procedure. The committee recommends that this criteria be retained for the expansion of certain ALS procedures, specifically the administration of intravenous (IV) drugs and IV fluids, and intubation; provided that the Research Advisory Committee use part of its budget to actively assist in the development of this research which would focus on both mortality and morbidity. The Research Advisory Committee should work collaboratively with base hospitals to develop standard research designs and implementation procedures.

C32. The ministry currently requires that a community have 911 service in order to receive automated defibrillation services. This requirement should be maintained, although the steering committee has recommended that the entire province be covered by 911 services, elsewhere in this report.

C33. For pain relief, or symptom relief, research and 911 should not be prerequisites, but base hospitals are necessary for medical control, and implementation depends on available funding. A symptom relief program should include a needs analysis and assessment of patient conditions that the program will affect; documentation of ambulance call volume and patient type; an evaluation of initial training needs and identification of continuing medical education and clinical practicums for ongoing skills maintenance; description of evaluation mechanisms to ensure quality control; and a description of how the program will be implemented operationally. Although not a prerequisite, a design for publishable research should be encouraged. The outcome, or therapeutic endpoints must be defined, and should include both negative and positive

impacts and expected patient care benefits to be derived.

C34. *The College of Physicians and Surgeons should explore removing 'pain relief' from the list of delegated medical acts.*

C35. *Data must be collected by all programs for needs analysis and once a program is implemented, for purposes of on-going evaluation. The province and where appropriate, municipalities must provide assistance and resources as required.*

C36. *Community colleges should consider future implementation of ALS training modules. These modules should be developed in cooperation with base hospitals and include an assessment and reporting module. Such modules should be standardized throughout the province.*

C37. *Consideration should be given to having a member of the Provincial Base Hospital Advisory Group sit on the Research Advisory Committee, assuming she or he is qualified to act in this capacity.*

C38. *The existing system wherein the sole responsibility for certifying ambulance officers to perform delegated medical acts rests with the base hospital medical director, should be maintained. As is now the case, officers would perform only those acts for which they have been certified, regardless of training level attained at a community college or other training institute.*

Non-emergency Transfers

Over the past decade there has been a significant increase in the number of non-emergency transfers provided by Ontario's ambulance service. Between 1980 and 1989, ambulance calls involving non-emergency transfers of patients to, from and between health care facilities grew by almost 40 per cent. This increase has been prompted in part by changing demographics, as well as provincial health policies emphasizing rationalization and regionalization of institutional health resources.

The current system for providing non-emergency transfers has resulted in discomfort and inconvenience for patients. It has also resulted in inappropriate use of ambulance equipment and personnel, as costly emergency vehicles are deployed on non-emergency calls and ambulance officers assume portering functions.

C39. *The patient transport system should be tiered into three categories, according to severity of the patient condition: 1) air ambulance, critical care transport unit and paramedic vehicles for the most severely ill or injured, 2) ambulance vehicles for Codes 1 - 4, with possible designation of the vehicles for Codes 1 and 2, where appropriate, as ambulance transfer vehicles, such as multi-patient units, where appropriate; 3) and the range of services that exist outside of the ambulance system, such as taxis, personal vehicles, Wheel Trans, etc.*

C40. Hospitals should be given more responsibility for patient transportation decisions, in the form of a transportation budget, out of which all patient transport, including ambulance, would be paid.

C41. Institutions should attempt to determine what is the most appropriate mode of transport, based on the criteria that patients who require a stretcher and/or on-going medical attention should be transferred via land or air ambulance. An ambulance crew should be in attendance for Codes 1 and 2 transfers.

C42. The ministry should develop criteria for use of non-ambulance vehicles.

C43. Receiving hospitals should institute block booking for those services used by patients requiring ambulance transport. This would define times giving priority to these patients.

C44. Non-urgent transports should be booked by sending facilities at least 24 hours in advance through a CACC.

C45. There should be a scheduled transportation system in the north that delivers people to centres offering block booking.

C46. Codes 1 and 2 calls should be done on a door-to-door basis. Institutions should be given ambulance stretchers to facilitate this procedure.

C47. The EHS and Institutional Care branches of the Ministry of Health, the Ministry of Community and Social Services and the Ontario Hospital Association should establish an implementation group to work with DHC's to develop a multi-tier system of patient transport and care, that functions on a door-to-door basis, that schedules the departure and arrival of patients, utilizes the concept of block booking, attempts to develop appropriate response time standards and enhances career development within the ambulance system. Any cost savings realized through the development of efficient patient transfers would be reallocated to other aspects of health provision in those geographic areas.

C48. Where volumes warrant, dedicated transport vehicles operating either on a schedule or ad hoc basis should be implemented by ambulance services. These vehicles would be exempt from answering emergency calls and would be staffed by ambulance attendants.

C49. The EHS should do extensive education with hospitals, nursing homes and home care services and their sponsoring ministry departments to encourage use of non-ambulance services for patients who can appropriately use them.

C50. Non-ambulance patient transport services should be regulated.

D. RECRUITMENT, RETENTION, MOBILITY & CAREER DEVELOPMENT

Funding Issues

In some ambulance services and in most dispatch services, low wages result in retention, recruitment and staff turnover problems. Discrepancies in wages, benefits and pension plans within the system exacerbate these problems.

Some solutions to these disparities are most appropriately left to the collective bargaining process.

Income disparities between ambulance and other emergency services produce a retention problem within the ambulance system. Workers use the training and experience gained in ambulance work as a stepping stone to the higher paid, higher status professions of fire and police work.

D1. *Greater value in both monetary and non-monetary terms should be placed on employees within the ambulance system.*

Service and Structure Issues

Discrepancies in the processes and structures of labour/management relations and the fragmented structure of the emergency health system itself create barriers to mobility.

There is also a limited range of career options in this sector. When ambulance officers get injured, burnt out, or simply want a change, they have a limited number of alternatives. Many leave and their skills, experience and dedication are lost to the system.

D2. *To promote retention and mobility and to acknowledge the need for modified work programs, the pre-hospital emergency care system should be restructured to allow for greater variety of job opportunities. New career options within the system could include training and public education programs, public relations and non-emergency transfers.*

There is also a lack of mobility between the emergency health system and other health care professions. This is partly because EHS skills are not recognized by other professions and because there are no clear educational standards.

D3. *The Ministry of Colleges and Universities should be encouraged to promote more cross career training.*

The very nature of the work in emergency medical services and the way it is organized is stressful. It puts enormous strain on family life, which in turn, increases the stress experienced. This contributes to the retention and burnout problem.

D4. Applicants should be made aware at the recruitment stage of the nature of the work and the demands it places on those performing it.

Recruitment barriers, such as lack of promotion designed to attract women, visible minorities, people with disabilities and francophones into the service, and a lack of programs within the service to meet the needs of these employees, frustrate employment equity goals.

D5. Promotion programs should be focused to attract individuals from the target groups into the service. Provided that all applicants to college training programs are qualified, they should be admitted on employment equity considerations, rather than on a first come, first served basis. Child care must be provided in the colleges, both to attract women to the program and to recognize and support parental responsibilities of men.

D6. The profession must be made more attractive and accessible to the target groups. There should be an examination of the services to determine appropriate programs, for example, child care, job accommodation, 'four for five' programs (where employees work for four years at 80 per cent of remuneration, bank the remaining 20 per cent and take the fifth year off), and improved outreach in recruitment.

Management/Labour Issues

Some ambulance services do not invite or welcome employee participation in day-to-day operational functions. There is also a lack of involvement within the service in the development of both local and ministry policies.

D7. There should be labour/management committees established where they do not already exist, to enable the parties to discuss and resolve day to day operational issues.

D8. There should be a mechanism to permit greater involvement of managements and unions in ministry policies.

D9. Training programs to improve management techniques and to encourage a more progressive and participatory management style must be established for both management and employees.

Some operators require staff to do non-ambulance work. For example, some hospital services require employees to do security work, portering, and delivering newspapers. This interferes with the service's ability to respond quickly to emergency situations, lowers staff morale, and reinforces the low professional and public status of the service.

D10. Appropriate legislation and/or regulations should be amended and enforced, to remove the possibility that ambulance officers are required to perform inappropriate duties.

Profile

Lack of clear definition of the service and of those who work within it contributes to the low status and profile generally accorded to the emergency health care system and professional. Lack of professional recognition by the government, the medical community and the public creates a lack of respect for the contribution made by the service and an undervaluing in terms of funding and appreciation.

Neither the Ministry of Health, nor the Ministry of Colleges and Universities has a standard or comprehensive promotion and outreach program designed to attract people to the service, give them a clear understanding of the job and generally, build the profile of the service with the public.

Ambulance services have to compete with other emergency services - fire and police - for good candidates. Ambulance work is frequently used as a stepping stone to these higher profile, higher paid careers.

The low status generally accorded to the service manifests itself in a number of ways and contributes to low morale of those working within the service. At the most basic level is the physical presence of the service. In some communities, the ambulance service is "hidden" on back streets, in cramped and uncomfortable quarters. In some services, basic workplace needs, such as cleanliness and hygiene, comfort and space, are not being met. Some services have cockroaches, others do not have a place for employees to wash their hands.

D11. *Ambulance workers need a name and an identity that indicates their work and the service they provide.*

D12. *Addressing the internal morale problem is a prerequisite to addressing the low status and profile of the service. Attention must be paid to the physical presence of the service - both in terms of location and visibility in the community and in terms of physical comfort of those working in the service. All existing ambulance stations must meet the ministry's minimum standards according to a date and plan determined by the ministry's response to the proposed amendments to the Occupational Health and Safety legislation dealing with health facilities. The plan should be made public on or before December 31, 1993.*

D13. *There should be better promotion of the emergency health care system. Promotion programs must be focused on recruitment, to attract competent applicants and to apprise them of the nature of the work. Promotion efforts must also be directed to the popular media, to create a higher level of public recognition and appreciation of the service.*

D14. *Ambulance officers should be encouraged to enhance their professional status. This could occur through formation or membership in a professional association or through trade union activity designed to increase professional status.*

Early Retirement

It was noted that few ambulance officers retire from this profession, and that in fact, most leave in their forties and fifties. Some leave because they are disabled, others because of the very nature of the work - the heavy lifting, risk of personal injury and the stress.

D15. The Ministry of Health, in conjunction with the service operators and trade unions, should investigate the potential for establishing an early retirement plan for ambulance officers. To emphasize the importance of this proposal, it must be noted that identical recommendations were made by the Emergency Medical Attendant Review, and the Shapiro Commission.

Stress Issues

All who work in ambulance services agree that this is stressful work and that there are a number of issues that must be addressed. Stress originates from a variety of sources, including organizational, psycho-social and physical factors.

Important organizational stressors include those relating to shift work, work load, wage disparities and the bureaucratic nature of the system.

Psycho-social stressors include the cumulative pressure of dealing with people at their worst, with no resolution, and dealing with trauma, death and bereaved families. These stressors are exacerbated by the lack of programs within the system dealing with critical incident stress. Other important psycho-social stressors are the fear of injury and/or infection and concerns about job security and future employment.

Physical stressors include heavy lifting, driving in adverse conditions, inadequate workplace facilities (ie. cramped quarters and poor facilities for personal hygiene), inappropriate numbers and utilization of vehicles, and faulty and inappropriate communications systems.

D16. Job related stress should be viewed as a compensable illness by the Ontario Workers' Compensation Board.

D17. Appropriate levels of staff are needed to provide service and maintain complement when staff are called outside of the ambulance service's coverage area. The EHS branch should re-evaluate staffing levels and develop appropriate standards for staffing and workload levels through a standard-setting process with broad input and ensure that the standards are maintained at all times, within available resources.

D18. There are no ongoing critical incident stress management programs provided at the local level for emergency health care workers. Programs are organized on an ad hoc basis with fire and police departments after the occurrence of a major incident. There should be an ongoing

program developed by the government and made available to all emergency health service employees, with appropriate support and resources.

D19. *There is little stress management training within the service. The Joint Occupational Health and Safety Committee should be charged to deal with stress, as a high priority. It should examine such initiatives as the development of ongoing programs providing stress training and stress coping strategies. It should also advise the ministry on the development of an organizational delivery mechanism for ongoing stress programs, such as the development of stress management counsellor positions, with special consideration given to ensuring that these programs are accessible locally to all who work within the system.*

D20. *Stress training and coping strategies should be included in the college training program.*

D21. *There is no present requirement for defensive driving training. Many graduates of the college-based Ambulance and Emergency Care program have never driven an ambulance, as some of the colleges offering the course do not have ambulances. Defensive driving training in an ambulance should become part of basic training for ambulance officers.*

D22. *The Ministry of Health should ensure appropriate communications equipment throughout the ambulance service. There is a need for portable communications devices for the crew to ensure full communications ability and to prevent an occupational health and safety incident related to poor communications.*

D23. *The EHS branch should educate hospitals and other health care facilities to encourage them to advise dispatch of the patient's weight.*

D24. *There should be a greater emphasis on physical fitness by management and employees. It is understood that recommendations on physical fitness standards will be forthcoming from the Joint Occupational Health and Safety Committee.*

D25. *Standardized physical fitness programming should be part of the college training for ambulance officers.*

D26. *There should be improved education of management and employees regarding their rights and obligations in unsafe or potentially unsafe situations. Officers, for example, should be encouraged to call for help in situations requiring unreasonably heavy lifts.*

D27. *Ambulance officers should have all information pertinent to the care and safety of the patient and themselves. Protocols should be established to ensure that dispatch is informed of any potentially hazardous situation of heavy lifting, infection, violent behaviour, etc. and that ambulance officers are informed at the time of dispatch, to ensure that they are prepared for the situation.*

D28. *The practice of part-timers of working back-to-back shifts for different employers could*

affect the care of the patient and is a potential health and safety problem for the worker. The practice should be discouraged.

D29. *The Joint Occupational Health and Safety committee should examine the body of knowledge regarding the impact of shift work and produce an educational package for employees and management explaining how shifts should be scheduled and outline useful lifestyle and coping strategies.*

Training Issues

Accreditation of ambulance officer training programs is important to ensure that community college programs consistently produce competent graduates. It also ensures achievement and ongoing maintenance of educational standards, and creates portability of qualifications.

D30. *The Ambulance and Emergency Care Program taught in Ontario's community colleges would be accredited at the Canadian Medical Association Level II, if it included training in two procedures, initiation of IV therapy and administration of nitrous oxide. To permit accreditation at the CMA Level II, the Ambulance and Emergency Care Program should be expanded to include training in these two procedures. In addition, the Ministry of Health, at the appropriate time, should make graduation from an accredited Level II program a prerequisite to challenging the EMCA certification examination.*

D31. *The colleges should be encouraged to introduce greater practical examination during the training of ambulance officers. A formal preceptor program should be developed by the Ministry of Colleges and Universities as soon as possible. This should include appropriate training, certification and remuneration for preceptors.*

D32. *There should be a sufficient period of on-the-job orientation to introduce new employees to matters such as WHIMS, occupational health and safety, driving skills, system and local policies and procedures, and local geography.*

D33. *Limited availability of educational facilities in remote areas make it a necessity to consider alternative hiring standards in these locales. Nonetheless, the Ministry of Colleges and Universities should be responsible for developing innovative programs to extend educational opportunities to these remote areas.*

EMERGENCY MEDICAL SERVICES REVIEW

Appendices

1. Announcement, Terms of Reference, EMS Review

2. Schematic diagram of structure, composition of EMS Review

3. Bulletins #1, #2 and #3, EMS Review

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February 14, 1991

I am pleased to inform you that the government has approved a review of the Emergency Medical Services Sector to focus on future directions, governance and labour/management relations. The review is to be completed in 1991 and will be conducted by the Ministry of Health with assistance from Management Board staff.

As you know, both rapid expansion and the introduction of new service technology have affected the existing delivery structures of Ontario's emergency health services.

We have a strong network, a good foundation -- but there is a need to build on the improvements that have taken place. In particular, air and land ambulance services and centralized communications must adapt to the changing demographics in Ontario. And we must take advantage of opportunities to extend mutual aid agreements in support of 911 systems. It is extremely important to foster closer relationships between ambulance, fire and police services so our efforts are better co-ordinated.

A number of factors have had an impact on labour relations in emergency health services. In some cases, employer/employee relations have been affected by the rapid expansion of services. We know the review should address, among other things, wages, working conditions and health and safety.

An important consideration will be last year's determination of the Ontario Public Service Labour Relations Tribunal that the employees of certain ambulance services were Crown employees within the meaning of the Crown Employees Collective Bargaining Act -- and that the owner/operators were agents of the Crown.

In its review of the system the government will assess future directions, examine management controls, employer/employee relations and governance. The study will give consideration to the history of labour relations, the presence of a number of bargaining agents and employers, and compensation within the sector. It intends to do this by thorough consultation with all concerned.

To that end, the Ministry of Health will provide, in the near future, information on the consultation process and the presentation of submissions.

The Terms of Reference for this review are to include the following considerations:

1) to examine the future needs of the emergency land and air ambulance services in Ontario;

2) to strengthen non-emergency (inter-institutional) transportation services to meet community needs recognizing changes in demographics and the effects of technology on the delivery of health care;

3) to explore opportunities for the improvement of service delivery and communication linkages with allied emergency service providers;

4) to improve standards to assess management and service delivery;

5) to examine the current management service delivery structures (Ministry, hospital, municipal, private, volunteer) and recommend future governance arrangements;

6) to address the implications of the Tribunal's decision and the settlement for the entire ambulance sector, where a number of unions have representation;

7) to examine labour management relations and develop recommendations for the improvement of collective bargaining practices for ambulance services; and

8) to review existing legislation governing emergency service operations and collective bargaining arrangements.

I look forward to your participation and co-operation in this review.

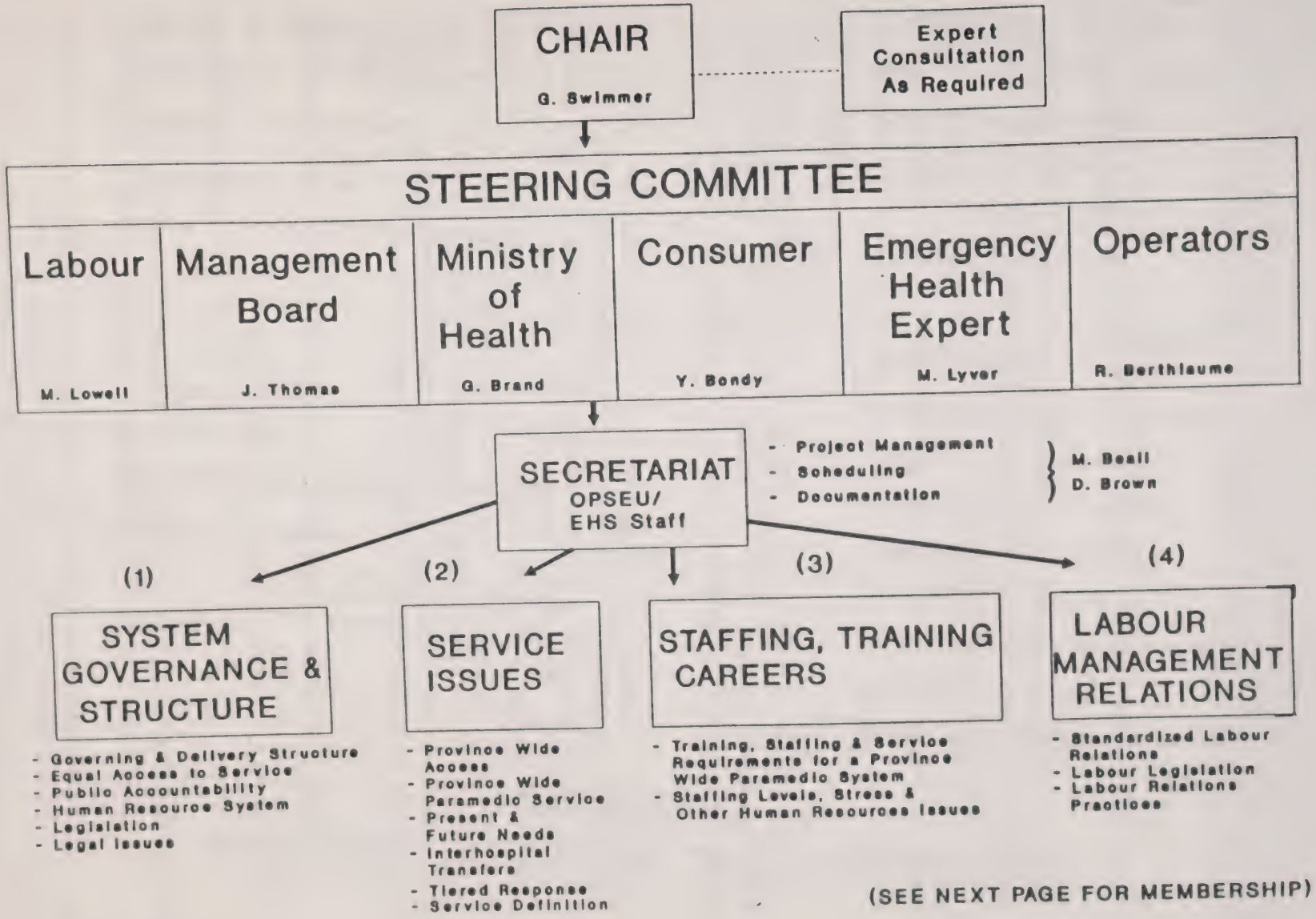
Yours,

Evelyn Gigantes

Evelyn Gigantes, M.P.P.
Ottawa Centre
Minister

Draft, July 30, 1991

EMERGENCY MEDICAL SERVICES REVIEW



(SEE NEXT PAGE FOR MEMBERSHIP)

EMERGENCY MEDICAL SERVICES REVIEW
MEMBERSHIP

(1) Unions - J. Benard
- J. Cowan
- R. Nahls

Operators - J. Moore
- E. Barton
- M. Bullock

Health - M. Bates

Management Board - D. Green

Resources:
Management
Lawyer

(2) Base Hospitals - J. Dreyer

Provincial EHS

Adv. Comm. - G. Dagnone

Unions - G. Smith

Health - B. Forsyth

Operators - D. Powell

O.H.A. - B. Barabell

Sol. General - A. Banack

Consumers - J. Fulton
- J. McEwen

(3) Base Hospitals - B. Field

Unions - L. McKean
- R. Behie

Health - R. Armstrong

Operators - A. McDooling
- W. Morris

H.R.S. - C. Mudge

Coll. & Univ. - J. Whittle

(4) Unions - G. Armes
- R. Armstrong
- B. Sheehan

Health - J. Crawford

H.R.S. - D. Green

Min. of Labour - R. Prial

Operators - P. Whalen
- M. Sanderson
- B. Paxton

EMS Review Bulletin

August 1991

The Emergency Medical Services Review has begun its examination of Ontario's emergency health system.

This is the first of a series of bulletins that will be produced in the course of the review. Interested groups and individuals are encouraged to provide the review with their thoughts on the matters under consideration. In particular, they may wish to make a written response to the Issue Statements that were prepared to guide the work of the review's working groups, which are attached to this bulletin.

Terms of Reference

The review was announced earlier this year by the Hon. Evelyn Gigantes, then Minister of Health. Its terms of reference are to develop recommendations for improvements in management and service delivery, governance arrangements and labour/management relations.

The review will examine the new demands being placed on emergency health services - changing demographics, technology and changes in the way health services are delivered and recommend service improvements. It will explore opportunities for better linkages with allied emergency service providers. It will examine current management and service delivery structures and recommend future governance arrangements. And it will focus on labour/management relations within the sector, addressing the implications of the Ontario Public Service Labour Relations Tribunal decisions that employees of certain ambulance services are Crown employees and that the owner/operators are agents of the Crown.

The review will report to the health minister by the end of the year.

Review Structure

Dr. Gene Swimmer, director of the School of Public Administration at Carleton University in Ottawa, has been appointed as chair of the review.

A broadly representative steering committee has been established to oversee the work of four working groups. The Hon. Frances Lankin, Minister of Health attended the first meeting of the steering committee to discuss the terms of reference, timing and the importance of the review. The steering committee has

approved issue statements which will be used to guide the work of the working groups. This committee will meet monthly until the review is complete.

Four working groups have been established to examine questions relating to system governance and structure, service issues, staffing, training and career development and labour/management relations. The working groups are comprised of representatives appropriate to the issues being considered. They will begin their work in early September and will continue meeting about every three weeks until their work is complete.

Research

The review has contracted with Katherine A. Graham, CMC, Management and Research Consultant to conduct a study of models of emergency health services organization across Canada, in the United States and OECD countries. This will assist the review's deliberations about the future structure and governance of emergency health services.

Steering Committee Membership

Labour

Mark Lowell
Ambulance Attendant
Ontario Public Service Employees Union

Management Board

Jim Thomas
Assistant Deputy Minister
Employee Relations And Compensation Division
Human Resources Secretariat

Ministry of Health

Graham Brand
Director, Emergency Health Services Branch

(cont'd.)

Consumer

Yvonne Bondy
Community Care Committee
Essex County District Health Council

Emergency Health

Dr. Marion Lyver
Emergency Health Services Branch
Ontario Ministry of Health

Operators

Rene Berthiaume
Ontario Ambulance Operators' Association

System Governance and Structure Working Group

Statement of Issues to be Addressed

Ontario's emergency medical service network, while based on a solid foundation, must adapt to evolving needs. The changing demographics of Ontario's population, combined with changes in the way health services are delivered, and the introduction of new technologies have put new demands on the emergency medical service network. If left unaddressed, these demands threaten to create inequities in both the type and quality of services received by people across the province. The management and organizational structure of the system must be capable of responding to these pressures.

Like other health services, the emergency medical care system is under increasing financial pressure. Declining federal transfer payments for health care and increasing demand for all types of health services means that new funding is limited. It creates an even greater need to ensure effective, efficient delivery of emergency medical services.

There is another motivation for change, and that is the desire on the part of those who work within the emergency health care system - both employees and managers - to develop a mature labour/management relationship. Recent Labour Relations Tribunal decisions give additional evidence of the need to rationalize the structure of ambulance services. The Tribunal determined that employees of certain ambulance services were Crown employees within the meaning of the Crown Employees Collective Bargaining Act, and that the owner/operators were agents of the Crown.

The task for the review and for this working committee is to identify a governance and management structure that can establish a comprehensive emergency medical system which ensures a high standard of service throughout the province. This structure must contain the following characteristics:

- It must be responsive to changing needs and accountable to local communities;

- It must be flexible enough to provide a range of services that could include dispatch, non-emergency transfers, air ambulance, basic life support, advanced life support services and public education and research;

- It must build workable and cost-effective linkages between other emergency services, specifically, fire and police;

- It must foster progressive and constructive labour relations, encourage greater involvement of those who work within the system in its overall direction, and improve career development opportunities within the system;

- It must be a cost-effective response to current and future demands.

A number of alternatives to the present structure have been examined by different parties. The Ministry of Health has examined a number of options, including further privatization of the system, devolvement to municipalities, a ministry-operated system and the creation of a crown corporation. The Ontario Association of Ambulance Operators has proposed that the provincial government either divest responsibility for direct operation of ambulance services or take over all responsibility for these services. The unions favour a publicly-funded, publicly-controlled single entity that provides all emergency medical services in the province.

The Governance and Structure Working Group should examine the above options in detail, with reference to their ability to accomplish the above-stated goals. It should determine whether all current and future emergency health-related services would be better provided by one agency or whether certain services should be provided through other auspices. It should advise on the legislative framework, the funding mechanism, and anticipated costs.

Models from other jurisdictions should be examined, as well as models for providing other kinds of emergency or protective services, to determine what characteristics are most appropriate for our situation.

Service Issues Working Group

Statement of Issues to be Addressed

Ambulance services are a critical component of the health care system. Their role is to provide emergency transportation to hospital and life-sustaining care to people needing emergency medical treatment. They also provide medically necessary transportation between health care facilities or between home and hospital.

While Ontario enjoys a high standard of emergency health care, there are growing inequities within the system.

★ Response times vary considerably throughout the province, depending on locale and type of service available. Metro Toronto's average response time is the quickest, at 6.3 minutes. Ministry-run services are next, with a response time varying from an average of 6.8 minutes in large urban areas to 10 minutes in rural southern Ontario areas. Hospital, municipal, private and volunteer services have longer response times, ranging up to longer than 1/2 hour in remote northern areas. (note: 1986 response time data; information is being updated.)

The working group should examine response time and other criteria to assess service quality and determine which criteria should be emphasized. If it determines that response time is the most appropriate measure, it should assess what measures could reasonably be taken to improve response times, given service, human resource and cost implications.

★ Full paramedic, or Advanced Life Support services are available in Hamilton, Toronto and Oshawa. Automatic defibrillation, an ALS procedure, is available in 13 other Ontario communities. These services, while funded by the Ministry of Health, may not have been introduced in an optimal manner. Criteria imposed by the Ministry and the College of Physicians and Surgeons for provision of paramedic services have received criticism from a variety of sources and need to be examined. Specific ALS procedures need to be examined for efficacy and cost effectiveness, in the Ontario context, to assist in determining how the service should be expanded. The committee must address the question of whether expansion of these services should be made contingent on conclusive research. It should attempt to define criteria for obtaining ALS training.

★ In a number of communities throughout the province, fire, police and ambulance services have built upon a tradition of mutual co-operation and established informal and formal agreements outlining how the agencies could call on each other for assistance.

Tiered response agreements exist in at least 10 Ontario communities and vary from community to community, with most communities having informal mutual aid arrangements, which are activated on an "as requested" basis.

A variety of problems have arisen out of the implementation of these agreements, including unclear dispatching protocols, increased call volume, increased costs, competing priorities, liability questions, and training questions.

There should be a determination of the appropriate roles and linkages between the three systems, with reference to response times, research on patient outcomes, geographic variances and cost.

★ Non-emergency or elective transfers comprise a large and growing portion of ambulance calls and at present account for about 45 per cent. This figure is expected to grow even more as a result of government policies encouraging more community or home based, as opposed to institutional, health care. Some non-emergency transfers may not represent an appropriate use of ambulance equipment and personal. Other non-ambulance-based services, some of which are unlicensed and unregulated, have entered this field in a number of communities.

A draft Ministry of Health review of elective transfers recommends that health facilities be provided with funds to purchase elective transportation services on a fee-for-service basis from private and municipal providers of alternate transportation services or from the local ambulance service. It also recommends that purpose-built vehicles be provided within the ambulance system to provide elective transportation services to the segment of the population requiring it. These and other options must be examined, with reference to the needs of the client population, including the question of whether the service is medically necessary or not, the organizational structure, and cost and service implications.

★ A number of communities in the province rely on volunteer ambulance services. Is this an appropriate level of service or should alternative arrangements be made? What are the staffing, service and cost implications?

Labour/Management Relations Working Group

Statement of Issues to be Addressed

The Ontario Public Service Labour Relations Tribunal determinations that certain private operators are agents of the Crown, as well as a desire within the sector to develop a mature labour/management relationship provide the impetus for change in the structure and practices of labour/management relations in this sector.

Much of the work of this committee is dependent on whatever recommendations emanate from the governance issues working group. Specifically, the labour/management relations working group needs to know what the governance and organizational structure will be and the time frame within which it will be created. It needs to develop a long-term plan to correspond with the ultimate governing structure and it needs to address the question of what intermediate or short term arrangements need to be made.

It is also understood that the collective agreements covering the designated Crown agents expire on December 31, 1991 and that decisions need to be made to enable negotiations to proceed. A key question is that of who the parties to the agreements are.

It is also understood that matters that are best left to the collective bargaining process will be left to that process.

This working group should advise on labour relations practices and the structures and practices of collective bargaining. If the status quo is not an option, the question arises as to who gets a job in the new system? What happens to the staff working in various categories of the present system, that is, bargaining unit members, management and excluded in all types of ambulance operations, as well as administrative staff working for the ministry? Will they all get jobs? What is the fairest process for making these determinations?

While it is understood that the existing unions wish to retain their existing membership, questions remain as to what happens to the unorganized workers and new employees.

How should the bargaining unit be defined ? - should there be a province-wide bargaining unit, or regional units? What should be the degree of centralization of bargaining? Should there be a province-wide agreement that covers everything, or should there also be local agreements covering local issues? What will happen to pensions and benefit plans?

How will disputes be resolved? Should there be full, limited or no rights to strike?

Will there be new job classifications, for example, non emergency transfers? How will classifications and wage rates within the new system relate? Should a job evaluation be negotiated to examine job relativity between, say, dispatchers and ambulance attendants; BLS providers and ALS providers?

How will mobility be encouraged within the system? How will postings and transfers be handled in light of the fact that four different unions represent members working throughout the province. For example, how would a woman working as an ambulance officer in Sault Ste. Marie, who is a member of S.E.I.U. be able to move to Hamilton, where employees are represented by OPSEU?

How will a participative, co-operative labour/management system be structured? While this discussion is somewhat contingent on the recommendations of the Governance/Structure working group, how can this objective be built in?

What should be the governing legislation for labour/management relations? Should they be governed by existing labour legislation or should there be new legislation?

How should the parties proceed after December 31, 1991? The working group should discuss an interim plan.

Staffing, Training & Career Development Working Group

Statement of Issues to be Addressed

Parties involved in the emergency medical services system generally agree that improvements are needed in the overall management of human resources within the system.

The Shapiro Report reported stress and burnout as being a serious problem in ambulance and dispatch workers. Shapiro identified a number of factors contributing to these problems, including the incident stress associated with the nature of the work, wage inequities, perceptions of under-staffing, poor labour/management relations, erratic shift schedules and uncertainty about the future.

Since one of the goals of the review is to advise on ways to develop a mature and progressive labour/management relationship, it is hoped that many of these issues will be addressed in the recommendations on governing structure and labour/management relations.

★ The working group should examine the ramifications of various governance/organizational models for current employees. It should also attempt to determine appropriate staffing levels.

★ The working group should advise on appropriate training and qualifications for volunteers.

★ There is a serious retention problem in the sector. Ambulance officers note that they rarely see their colleagues retire from the job - most of them leave before retirement age. There are many contributing factors. Many officers leave the profession because of physical or emotional burnout or because of injury. The sector suffers the loss of highly trained and experienced staff.

The turnover rate is even higher amongst dispatchers. Key problems are high stress levels associated with the job, concerns about inadequate training, the low wage rates compared to ambulance officers and the lack of career advancement.

★ Mobility problems and the lack of career development is a major contributing factor to the retention problem throughout the emergency health care sector. There is little opportunity to move to another job, either in the province or in the system. The present fragmented ownership and organizational structure and individual hiring practices are contributing factors.

In addressing the issue of retention and mobility, the working group should examine ways to reduce the stress associated with the work. And it should identify mechanisms to encourage greater mobility throughout the system. It should determine, for example, what training is necessary to foster movement between the various kinds of services.

★ The working group should also explore costs and benefits of early retirement as an option for workers in the sector. The Emergency Medical Attendant Review notes that there is evidence from the police and fire services that such a pension system may reduce the cost in lost

manpower and disability payments.

* There are a variety of training issues to consider. The Emergency Medical Attendant Review expressed concerns about the appropriateness of the current training program for basic life support providers, relative to the work that they do. It noted, for example, that the Ambulance and Emergency Care Program taught in the community college system goes beyond the normal scope of the work of ambulance officers and recommends that content that is beyond the scope of practice of the basic life support provider be removed.

Ambulance officers have expressed a need for better multicultural and interpersonal skills training.

Concerns have also been raised about how current training in Ontario does not correspond with the National Standards of EMA 1,2 and 3.

The working group should attempt to determine whether in fact the current program is appropriate for basic life support providers and what, if any, changes should be considered. Does the course facilitate the advanced life support training done by base hospital physicians?

What mechanisms can be created to obtain advice on training matters in an ongoing manner from those who work within the system?

The idea of a central training facility for ambulance services has been proposed and should be explored.

* Advanced life support training is also an issue. What are the costs and benefits of training ambulance officers in advanced life support procedures? The working group should work in concert with the services working group which is addressing the connection between research on patient outcome and cost effectiveness and expansion of the service.

EMS REVIEW

Bulletin #2 - November 1991

The Emergency Medical Services Review is working to address critical issues facing Ontario's system of emergency health care. Since early September the four working groups have been meeting to discuss the problems assigned to them.

With their broadly representative composition, the working groups bring together diverse perspectives on the issues. The general approach is to develop a shared understanding of the issues and, if possible, a consensus on possible solutions. Where this is not possible, the differing opinions are noted.

Working group discussions have been facilitated by presentations and written material from individuals and organizations with particular knowledge in emergency health issues. A study of organizational models used in other jurisdictions that was commissioned by the Review has also informed discussion.

Review of Working Group Activity

1. System Governance and Structure

This working group is assigned the task of identifying an effective organizational structure for Ontario's future system of pre-hospital care.

Its deliberations have focused on structure and governance proposals received from a number of interested parties. The various models are being assessed according to criteria developed by the working group and steering committee.

As two of the models closely resembled those in place in British Columbia and Quebec, the group met with representatives from those provinces to get a better understanding of how these systems worked.

2. Service Issues

This working group is concentrating on four key service issues: response time, Advanced Life Support, tiered response and non-emergency transfers. It is drafting recommendations for the steering committee on these issues. The group has invited Yvonne Bondy and Dr. Marion Lyver from the steering committee to attend its meetings, to create a stronger liaison between the consumer representatives on the working group and the steering committee.

The group has met with Bernard Moyle, the Fire Marshall for Ontario and Dr. Justin Maloney, Medical Director of the Base Hospital/ALS Program at Ottawa General Hospital to discuss tiered response.

On the issue of Advanced Life Support it has met with Dr. Chris Rubes, Medical Director of the Base Hospital Program at Sunnybrook Medical Centre and Dr. Marion Lyver, Medical Consultant for the Emergency Health Services Branch. It is awaiting the results of a literature survey on Advance Life Support commissioned by the Review.

3. Staffing, Training and Career Development

To date, this working group has devoted considerable attention to the issues of recruitment, retention, mobility and career development within the pre-hospital emergency care system. It has developed a series of recommendations for the steering committee and has directed a number of issues for discussion into the deliberations of the system governance and structure and labour/management relations working groups.

The group has also begun discussions on the issue of stress, in order to develop recommendations on this issue.

4. Labour/Management Relations

This working group has focused on labour/management relations issues as they relate to the key structural models that have been proposed to the review. In particular, it has discussed dispute resolution mechanisms for the pre-hospital care system, measures to encourage career mobility and career development within the sector and issues relating to the structure of collective bargaining.

Comparative Review - Interim Results

Interim results of the comparative review of emergency health services in other jurisdictions were presented by Katherine Graham, consultant, to a joint meeting of the system governance and structure working group and the steering committee in early October.

The review examined nine Canadian and seven American jurisdictions, as well as systems in France, the United Kingdom, Germany, Italy, Sweden and New Zealand. The interim report outlined models of service and regulatory structures and summarized the trends and major concerns of ambulance services in these jurisdictions.

Major trends and concerns included trends toward increasing universal access, increasing centralization of standards and growing concern with issues such as cost accountability, and service issues such as provision of routine transfers and integration with other emergency services such as fire and police.

Types of service models ranged from those that were totally publicly-run by the province or state to more laissez-faire types with little or no legislation and voluntary standards. In between were models with varying degrees of central regulation that provided service through contractual arrangements with various types of providers.

Literature Review

A review of literature on Advanced Life Support has been commissioned with the Department of Prehospital and Emergency Medicine at McMaster University. Interim results are expected in early November and final results in early December.

Focus on the North

Dr. Gene Swimmer, Chair of the Review, attended the semi-annual North West Regional Ambulance meeting at the Quetico Centre, near Atikokan in early October and will be meeting with representatives from North East Ontario later this month. A director of a hospital-based service from the north will attend a System Governance and Structure working group meeting in early December to discuss northern concerns with the group.

Emergency Medical Services Review Working Group Representatives

System Governance and Structure

Management Board of Cabinet
D. Greene

Ministry of Health
M. Bates

Unions
J. Benard
J. Cowan
R. Nahls

Operators
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M. Bullock

Service Issues

Base Hospitals
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Consumers
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EHS Advisory Cttee
G. Dagnone

Ministry of Health
B. Forsyth

Ontario Hospital Association
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D. Powell

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Solicitor General
A. Banack

Staffing, Training & Career Development

Base Hospitals
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Human Resources Secretariat
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Ministry of Health
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Ministry of Colleges & Universities
J. Whittle

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Labour/Management Relations

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Ministry of Labour
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EMS REVIEW

Bulletin #3 - December 1991

The Emergency Medical Services Review is nearing completion. The working groups have concluded their deliberations, the steering committee has prepared its recommendations and Dr. Swimmer is writing the final report.

WORKING GROUPS

Final sessions of most working groups were held in the last week of November/first week of December. Because its recommendations were contingent to a large extent on resolution of the structure and governance issue, the labour/management relations committee completed its work at the end of October.

Each working group prepared a final report to the steering committee containing recommendations and a summary of deliberations. Participants were generally pleased with what they had accomplished, given their time frame and their diverse perspectives on the issues.

STEERING COMMITTEE

The steering committee met on December 5 and 6 to review the reports of the working groups and discuss recommendations to the Minister. Dr. Swimmer presented the conclusions of the labour/management relations and the system governance and structure working groups. Presentations were made by the two steering committee representatives on the service issues working group, Yvonne Bondy and Dr. Marion Lyver and by two representatives of the staffing, training and career development working group, Charlotte Mudge and Jim Whittle.

A wide-ranging series of recommendations were put forward by the steering committee on service and staffing issues. Covering matters such as access, response time, tiered response, Advanced Life Support, recruitment, retention, mobility, career development, stress, early retirement and training, these recommendations are all based on consensus of the steering committee.

While there were also consensus recommendations on issues relating to

labour/management relations and on general features of the future system, consensus was not possible on the central question of structure and governance of emergency health services. Each party has provided a comprehensive assessment of their and competing models and the final recommendations on this issue are being written by Dr. Swimmer.

NORTHERN FOCUS

Dr. Swimmer met on November 29, 1991 with representatives of the Northeastern Area Emergency Health Services Committee. The committee emphasized that universal standards are needed for issues such as pay, training, communications and access to the system; that the system must be flexible to local needs and accountable to local communities; and that EMS models designed for urban southern settings do not necessarily meet the needs of rural Northern Ontario.

ADVANCED LIFE SUPPORT LITERATURE REVIEW

Unfortunately, the review of literature on Advanced Life Support commissioned by the Review with the Department of Prehospital and Emergency Medicine at McMaster University was not completed in time for the Review. The Emergency Health Services Branch has assumed the contract and interested parties can contact Dennis Brown at 7 Overlea Blvd, Toronto, M4H 1A8 for a copy.

COMPARATIVE REVIEW: FINAL RESULTS

As reported in Bulletin #2, a comparative review of emergency health systems in other jurisdictions was prepared for the Review by Katherine A. Graham, management and research consultant. Professor Graham's study identified current trends associated with the structure and governance of emergency health services in the jurisdictions examined, described generic organizational models and attempted to evaluate the models using criteria selected after discussion with the Review.

Major trends identified in the study include a tendency for emergency health systems to be in a state of transition in many jurisdictions; a trend to increase standards and increase the role of central government in setting those standards; concerns about universal access; integration with fire and police services, a trend to centralized dispatch, etc. There is striking similarity between the issues identified in the terms of reference for the Emergency Medical Services Review and those identified in the comparative review as common trends. It is interesting to note that many North American systems are moving to adopt features that have long characterized Ontario's system, for example, a high degree of central regulation.

Five different types of service models were identified in the study: a totally public system; a municipal system; a contract model; central regulation and eclectic delivery; and a laissez-faire model. These were assessed according to criteria to determine the level of

consistency of service, public responsiveness, integration with other emergency services, effective human resource management, and cost consciousness.

Professor Graham concluded that the public and municipal models exhibited the most positive aspects.

The three models proposed to the Review are consistent with what Professor Graham would propose as better models. It is very clear what kind of model Ontario does not want. That is, a de-regulated, laissez-faire style of operation. And fortunately, according to the comparative review, that kind of system no longer seems to hold favour in any jurisdiction.

Interested parties can obtain a copy of the comparative review from Dennis Brown at the Emergency Health Services Branch.